Vol. 11 No. 1 2nd Class Mail Reg No. 2776 TORONTO January 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Despite severe budget restraints

ARF's agenda still full

Marshman: sophisticated policy

By Pat Ohlendorf

TORONTO — Because government grants have not kept pace with inflation, the Addiction Research Foundation of Ontario (ARF) has suffered a 13% loss in purchasing power during the past five years.

That's a loss of $3,700,000, said Joan Marshman, the foundation's new president.

Accordingly, staff numbers have been reduced (mainly through attrition), staff members have had to take on more work, innovative projects not provided for in the yearly budget can no longer be funded, and divisions must establish priorities for their programs.

"We have no basis for optimism that the foundation's grant for 1982-83 will represent a significantly better level vis-a-vis inflation than has been the case in recent years," Dr Marshman said.

Yet the prevailing tone of the new president's first public address to staff was not gloom and doom.

Despite budgetary constraints, Dr Marshman pointed out, excellence in ARF's programs in research, treatment, and public education continues. A recent audit report (prepared by five researchers from the United States) concluded: "ARF is *the* premier addictions research organization in the world today."

Nor does the immediate future look bleak, said Dr Marshman. There will be opportunities to:

- step up ARF's attempts to influence public attitudes and behavior toward drugs and alcohol through better use of the mass media and key people in the community;
- offer "more sophisticated policy advice" to government;
- expand epidemiological research and public education regarding cannabis because "it seems likely that cannabis legislation will ultimately be enacted;"
- assist provincial Native organizations because "there is some indication the federal government is planning to increase financial support for prevention and treatment/rehabilitation services for Native people;"
- increase the foundation's efforts in employee assistance and employee recovery programs.

As a research-based public institution, ARF has a responsibility to shift its positions and advice as new scientific information comes to light, Dr Marshman said.

One area where a shift should be considered, she said, is the foundation's belief in "the unqualified desirability of reducing the per capita consumption" of alcohol, because research now suggests that "regular, low level alcohol consumption" may protect individuals against cardiovascular disease.

EAPs still miss most workers

SAN DIEGO — Despite the enormous increase in employee assistance programs over the past decade, the majority of workers in the United States still do not have access to such programs for substance abuse problems.

James Lawrence, acting deputy administrator of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) said this is especially true in small and medium sized business. It is a serious problem which must be tackled.

"There is also a need for innovative programs for special populations such as women and minorities. Soon two-thirds of American women are expected to be working outside the home and there is a great need for alcohol prevention in the workplace," he said.

Mr Lawrence was addressing the annual meeting of ALMACA, the Association of Labor-Management Administrators and Consultants.

He said that between 1950 and 1973, occupational alcoholism programs increased from about 50 to 500 in the US. In the past eight years, the number has increased to more than 4400 programs in the private sector and more than 600 programs in the public sector.

Surveys of Fortune 500 companies and 250 financial, insurance, and utility organizations

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Magnitude of drug problems in US is 'stunning,' says Mrs Reagan

By Harvey McConnell

WASHINGTON — Understanding and confronting the enormous problem of drug abuse in the United States may mean saving a whole generation, says Nancy Reagan.

Mrs Reagan, wife of the US president, told a meeting here of the American Council on Marijuana (ACM) that she believes the council "is in the same business as the American Cancer Society or the National Safety Council — that of saving lives."

She noted that during the 1980 presidential campaign, she visited Daytop Village, a drug treatment centre in New York, "and I was genuinely stunned by the magnitude of America's drug problem. There's no question that youthful abuse is now the overwhelming drug abuse problem.

"They are smoking, shooting, or sniffing while parents stand by feeling confused and heartsick. We've come to realize there simply aren't any soft drugs — they're all dangerous and damaging."

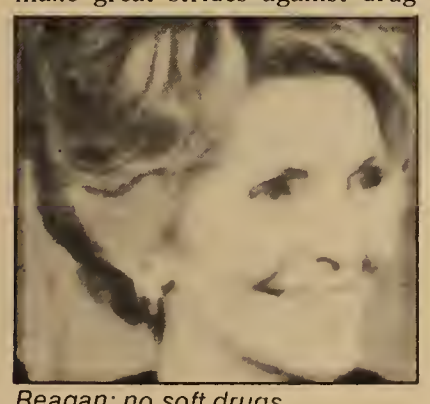
Mrs Reagan said that since her Daytop visit and the election of her husband as president, she has taken an active interest in drug abuse, "trying to learn its causes and consequences and trying to bring public awareness, particularly parental awareness, to the drug disaster.

"So many families are simply at a loss about how to handle a drug-using youngster — can't change their attitudes or behavior and can't rebut the messages the youngsters are getting from the rest of society."

She said that young people have "picked up quickly" on the borrowed sanction "social" drug use now enjoys.

"They get the words from music and much of today's humor, through publications for drug users and the widespread sale of drug paraphernalia. My heart goes out to these parents and to the young people — many of whom are crying out for help and guidance."

Mrs Reagan said that if parents, educators, and private groups like the council work together, "we can make great strides against drug abuse and perhaps save a whole generation that we are in danger of losing."



Reagan: no soft drugs

She noted that when children are young they are innoculated against polio and diptheria and whooping cough.

"If only we could do the same for drug abuse. But by understanding the problems, I believe we can largely immunize our children to the drug epidemic."

The American Council's conference was on the national impact on education of marijuana. Mrs Reagan was briefed in the spring by Dr Robert DuPont, ACM president, and former director of the National Institute on Drug Abuse.

DiCarlo to UN for USA

WASHINGTON — Dominick DiCarlo, newly appointed United States assistant secretary of state for narcotics matters, will unveil future US policy on drug trafficking at the February meeting in Vienna of the United Nations Commission on Narcotic Drugs.

Mr DiCarlo, appointed by President Reagan to succeed Malthea Falco, is a New York attorney and former assistant US attorney, and a state senator.

He has been travelling extensively since his appointment. He has held talks in Peru, Colombia, and Thailand, and, this month, visits Pakistan and Burma before going to the Vienna meeting in February.

A state department official said: "These have been familiarization trips for him, talking to people who deal with these issues in our embassies and in other governments and discussing interests and goals."

US policy is currently being worked out by Mr DiCarlo and state department officials with their counterparts in the Drug Enforcement Administration and the department of health and human services.

Alcoholism survey

Exec quiz for '82

SAN DIEGO — A survey to uncover the special needs of executives in finding help for alcohol problems will be launched across the United States in January.

A confidential questionnaire for the executive alcoholism recovery survey (EARS) has been developed by the Detroit chapter of ALMACA (Association of Labor-Management Administrators and Consultants). It will ask recovering alcoholics at management level what is needed to reach other alcoholics of the same status.

It was pointed out at the annual ALMACA meeting here that although much has been published about alcoholism among hourly workers, and treatment made available to them, little is known about the needs of managers.

Thus, alcohol problems among management personnel often go undetected; this can mean loss of an employee with years of valuable experience.

The project aims to have responses from between 2000 and 3000 recovering alcoholics in management.

The survey will ask them to assess policies and techniques for motivating problem drinkers to seek help; describe the treatment they had; suggest any changes which may be needed in treatment to help salaried employees; and outline the factors they found most helpful in recovery.

INSIDE

NEWS

Briefly...

Sake suffers

TOKYO — As more and more Japanese have been taking to beer and imported whisky during the past decade, sales of the national alcoholic drink, sake, have been falling. To try to reverse the trend, the Japan Central Sake Association has opened a three-floor promotion centre in downtown Tokyo, the minister of agriculture has convinced the government to serve more sake at state functions, and manufacturers have been producing "drier" and "softer" sake to satisfy consumers' changing tastes. Meanwhile, offsetting domestic losses are rising sake exports: more than 792,000 gallons last year.

Expensive cutback

NEW YORK — When Washington recently cut federal funds for controlling cigarette smuggling, New York City officials estimated city losses of up to $15 million, and state losses of about $40 million in cigarette tax revenues. Before the cuts, government agents, helicopters, unmarked cars, and teletyped messages had been used to track interstate smugglers moving cigarettes out of tobacco growing states. With illegal, untaxed cigarettes in circulation again, all governments will lose — including Washington, which collects eight cents per package of cigarettes.

Undercover addicts

AURORA, CO — Two former policemen who said they became addicted to cocaine and marijuana while working undercover have been awarded workmen's compensation benefits for mental disability. John Arko and Jack Bisgard are to receive at least $18,500 apiece and $222 a week indefinitely, says an Associated Press report.

Klan cocaine charge

TORONTO — Charged with possession of cocaine for the purpose of trafficking is the national director of the Ku Klux Klan in Canada, James Alexander McQuirter. Police flagged down the "Grand Wizard of the Canadian Knights of the Ku Klux Klan" during a routine spot check last month, and found two ounces of cocaine and 5000 unidentified pills in his car. McQuirter, 23, is also charged with possession of an unregistered, restricted weapon and with driving while suspended.

Pushers pushed out?

NEW YORK — A cheerful new flower market at the northeast entrance of Bryant Park (42nd St and the Avenue of the Americas) is more than a neighborhood facelift. A combined effort of the Parks Council, the Bryant Park Restoration Corporation, the New York Public Library, and the Rockefeller Brothers Fund, the market is aimed at discouraging drug dealing and panhandling. But, as one dealer told a *New York Times* reporter: "It won't affect us either way, except maybe bring more people to the park."

Heroin abuse by women is going up; male oriented programs aren't helping

By Harvey McConnell

WASHINGTON — Opiates were the major new problem for women entering the 2000 federally-funded drug treatment centres in the United States in 1980, a survey by the US National Institute on Drug Abuse (NIDA) has found.

Beth Reed, of the Women's Drug Research Project, University of Michigan, said heroin addiction has been increasing at a faster rate for women than men.

In addition, she said, the figures for women who have used marijuana (61%) are no longer very different from those for men (75%). And psychotropic drug use is higher among women.

In the study, women accounted overall for only 28% of those treated. However, they were over-represented in some drug categories.

Of the total number of men and women treated for tranquillizer abuse, 51% were women; for sedative use, 38% were women; for amphetamines, 35%; barbiturates, 34%; heroin, 26%; other opiates, 33%; marijuana, 26%; and PCP, 25%.

Dr Reed said a major problem is that most drug programs have been designed to treat male heroin addicts and have had little success in attracting women into treatment, keeping them there, and helping them.

Information for the NIDA survey, which includes data gathered in Boston, Detroit, New York, Miami, and Los Angeles, shows women who enter treatment have a range of problems different from those of men.

Dr Reed noted that drug dependent women have higher levels of depression and anxiety, and lower levels of self-esteem than drug dependent men. They also have less confidence for the future.

Women are frequently stigmatized by other clients, have histories of being exploited, and think they have less chance than men to change their situation. As a result, they are more likely than men to use drugs to cope rather than for recreation.

A major problem for women is medical complications; they run a high risk of developing infections and disorders of the reproductive tract.

Dr Reed said: "In one study, we found that 43% of the drug dependent women in treatment had gynecological abnormalities at intake, and 56% developed additional abnormalities during treatment. A drug treatment program in Detroit reported that 81% of their women clients developed vaginitis and 24% had abnormal Pap tests."

Between 50% and 80% of women who abuse drugs have dependent children. Many cannot enter treatment until arrangements are made to take care of the children as they are single parents.

Employment presents a sorry picture as well. The survey found less than 50% of women entering treatment had finished high school; only 3% were continuously employed prior to admission, and more than 80% in treatment are unemployed at the time they leave the program.

Despite their problems, most of the women continue to care for their children. Often it is concern about the future of their children which motivates them to seek help.

Drug dependent women do, however, have less trouble with the law than men: in 1980, 36% of women clients and 54% of men clients had been arrested within the 24 months prior to treatment.

Dr Reed said data from the study show that to be effective, treatment programs must attend to the problems of women caring for their children and focus on their role as mothers.

"Family therapy has been found to hold great promise as a service for drug dependent women. Women's groups have proved to be particularly effective in helping women develop self-confidence, communication, and interaction skills.

"We do know that drug dependent women are motivated to seek treatment if they feel that the treatment services are appropriate to their needs. Demonstration programs specifically designed for women have proven to be more successful than traditional treatment programs in attracting these women into treatment."

EAPs need some chic

SAN DIEGO — Training supervisors to use employee assistance programs (EAP) for staff with alcohol problems is essential, but is not the only way to bring troubled employees into the system.

Richard Kilgus, area coordinator, and C. A. Coiner, coordinator, with the Reynolds Metal Company, told the annual meeting of ALMACA here that other case finding techniques have shown to be effective and it is important that those in the employee assistance field cooperate and share techniques. (ALMACA is the Association of Labor-Management Administrators and Consultants.)

They said a basic assumption made by program people — but seldom considered in depth — is the image of a program, and this includes those who staff the program.

They should look at their office through the eyes of the client and ask some questions: Does the office give the impression those working there have a professional approach? Does the appearance of the office signal that people there are on top of problems, or is it untidy? Is the foyer outside the office clean? Does the staff present a professional attitude?

"It is vital for EAP personnel to let folks know who they are, where they are, and what their program is about," Dr Kilgus said.

The coordinator should consider becoming involved in as many company-related activities as possible, on his/her own time, as well as attend departmental staff meetings to find out what supervisors and others think of the program.

Personal letters to employees at home, and community workshops have also been shown to be effective at Reynolds.

Dr Kilgus said it is necessary for the EAP coordinator to get known by staff at detoxification centres. "There are many revolving door detoxification clients who are able to remain in the system for a long time without ever reaching proper counselling or follow up care."

Prevention activities are another way of promoting success. Dr Kilgus said: "The primary goal of prevention is to keep people from getting into trouble. But, at the same time, it does improve the visibility of the program so that an employee is more likely to utilize the EAP if he develops a problem at a later point in time."

Dr Kilgus added: "We cannot depend entirely on supervisor training to make, or break, our individual programs."

MSWs need not apply

SAN DIEGO — A push to have social workers enter industry could prove to be a Trojan horse as far as occupational alcoholism employee assistance programs are concerned.

This is the opinion of William Byers, assistant director of the New York division of alcoholism and alcohol abuse and a former social worker. Mr Byers addressed the annual meeting here of ALMACA (Association of Labor-Management Administrators and Consultants).

He noted that in the past few years a small group of social work academicians has been pushing the idea of industry as a fertile field of practice for social work professionals. The group capitalizes on the success of occupational alcoholism programs to prove the "mythical field" of industrial social work practice exists.

Mr Byers said industry and unions are being told social workers are logical professionals to work in industry because their training would meet industry's needs.

At the same time, he suggested, the occupational alcoholism field is being led to believe the industrial social worker is adequately trained to identify and refer alcoholics to treatment programs.

What is happening is that the occupational alcoholism field "is aiding and abetting the influx of incompetent social workers into industry."

'Revenooers' rejected

WASHINGTON — The fabled United States "revenooers" are to be phased out by President Reagan's administration as it moves to close down the federal Bureau of Alcohol, Tobacco and Firearms.

Twenty small offices around the country have been told they will be shut down as Treasury officials work to eliminate the agency and have the Secret Service and Customs take over its work on gun laws, and illegal alcohol and tobacco operations.

The agency has been a target for years of fervent members of the National Rifle Association, the powerful gun lobby which keeps Congress and the executive branch impotent to tighten gun control laws.

Prevention needs higher profile at workplace

(from page 1)

found only 25% had programs in 1972; this had risen to 57% by 1979; and today is even higher.

Mr Lawrence said the National Institute on Alcohol Abuse and Alcoholism had helped contribute to the growth of programs, even though its investment between 1972 and 1981 had been only $47.8 million. The institute hopes to remain active and to assist the field through research (The Journal, Dec, 1981).

"Although research is likely to be restrained somewhat until the economy improves, there is not any reason to believe at the present time that either the institute itself, or its research or advocacy functions, are in any danger of major reduction or phase out," he added.

Mr Lawrence said that in the present state of the economy, more hard information is needed and this must be shared with the field.

"Even though there has been rapid growth, it is obvious employee assistance programs will have to continue to strengthen their record of accountability to preserve this momentum."

Reduction of federal assistance means there will have to be more innovation in keeping costs down. More thinking must be done about methods of treatment, as treatment is the most expensive component of the employee assistance program.

Mr Lawrence said there needs to be more emphasis in the workplace about alcohol prevention. As most of a person's waking hours are spent on the job, it is a natural place to disseminate information.

Employee assistance programs are producing results, "and the small and medium sized companies with about half the nation's workforce are a prime target for occupational program salesmanship.

"As federal resources and federal leverage are turned over to the state and local governments, the sphere of influence of business and labor leaders on the state and local level is going to be enhanced and can be brought to bear on development of a solid community care system for alcoholism and drug abuse and mental health," he said.

Alc/cancer risk

NEWARK, NJ — Drinking puts a person at greater risk of oral cancer than does smoking, say Dr Arthur Mashberg and his associates at New Jersey Medical School. The team found more heavy drinkers among 181 squamous cell cancer patients than in a group of non-cancer patients.

NEWS

School survey shows some stabilization in drug use

Alcohol, tobacco, cannabis still student favorites

By Pat Ohlendorf

TORONTO — Drug use among Ontario junior high and high school students has levelled off since 1979, a province-wide survey shows.

The study, conducted by the Addiction Research Foundation (ARF), indicates alcohol, tobacco, and marijuana are still the most popular drugs among young people, with alcohol being the most prevalent (75% of the students surveyed have used it, but only 2% have done so four times per week or more). Tobacco is the most heavily used, particularly among females. Although only 30% of the students said they smoked, 72% of those reported daily use.

In breaking the information down by regions, Metropolitan Toronto was found to have the lowest rate of drug use and Western Ontario the highest.

The study, third in a series of bi-annual surveys, gathered information from more than 4000 students in grades 7, 9, 11, and 13 from 28 public and separate school districts throughout Ontario. Confidential questionnaires elicited information on alcohol, tobacco, marijuana, barbiturates, cocaine, heroin, speed, PCP, stimulants, tranquillizers, hallucinogens, glue sniffing, and solvents.

Of the major finding — that overall drug use has not increased during the past two years — the report comments: "This is most unusual, as past surveys in Ontario and in Metropolitan Toronto since 1968 have shown consistent increases in the use of cannabis and, in earlier years, alcohol use."

Smart (left) and Goodstadt: Metropolitan Toronto had the lowest rate of drug use, and Western Ontario the highest.

This year's levelling off, the report continues, may reflect "some stabilization taking place in the use of cannabis and the other drugs which had shown an increase in 1979" — a stabilization which has also been suggested in United States studies among high school students.

"Whether this is due to improved education about adverse effects of cannabis, economic factors, or more general sociocultural changes, cannot be determined at this time," the report states. (It's also possible, the report suggests, that the apparent lack of increase may be the result of changes in this year's sampling procedures.)

Other, more detailed findings of the survey include:

- Cannabis use declined "non-significantly" between 1979 and 1981, but was still significantly greater than in 1977;
- Alcohol showed no significant changes in prevalence for the third survey in a row (covering six years);
- Use of solvents other than glue declined since 1977 and 1979;
- Only non-prescription stimulants and LSD increased in prevalence, although this was only statistically significant when compared to 1977 levels;
- Males reported more frequent use of cannabis, prescription barbiturates, heroin, and cocaine, while females reported heavier tobacco use;
- Since 1979 males have been using less tobacco and alcohol;
- The youngest students (age 13 or less) reported less drug use than any other groups except in regard to glue and other solvents, which they used more frequently than the older students;
- The oldest group (18 and older) were "more conservative" than 16- and 17-year-olds in the use of all drugs.

Although it is difficult to explain why Western Ontario has the highest levels of drug use in the province (ascribing this to its proximity to the US may be too facile, according to one researcher), there are some interesting speculations as to why Toronto appears to have the lowest levels of drug use.

"Despite the aura of evil surrounding the big city, Toronto has always tended to be amongst the more conservative areas in drug use," Michael Goodstadt, one author of the report, told **The Journal.**

"There are at least two possible explanations for this finding. In a big city, kids who have problems or get into using drugs have more options in terms of leaving school, and we only surveyed the schools.

"The second thing is that, in spite of what you might imagine, walking down Yonge Street, many kids in Toronto come from new immigrant families, which tend to be very conservative regarding drugs and alcohol."

ARF has been conducting surveys on alcohol and drug use among Ontario adolescents for more than 10 years. In 1977 the current series, developed by Dr Reginald Smart, Dr Goodstadt, and Margaret Sheppard, was initiated.

Critics tackle heroin plan

SAN FRANCISCO — A program to reduce petty crime by heroin users has sparked controversy here between police and civil rights advocates.

Under the program, section 11550 of the state health and safety code has been revived to place heroin users behind bars for three months if caught under the influence.

Police and narcotics officers are in favor of the law; it leaves judges no option but to sentence heroin users. And police claim the burglary rate dropped after six officers, trained to spot subtle signs of drug use, made 253 narcotics arrests in a six-week trial program in 1980.

But critics complain police are wasting their time chasing small-time users, and they charge that narcotics officers frequently violate the rights of those arrested.

"The whole program is a sham," said Pete Keane, chief attorney for the public defender's office. "It allows a police officer to make a clinical judgement for which he is not qualified."

Sauntering up thirsty to the bar of progress

By Wayne Howell

"You can take this rat-race and shove it," declared Randy.

Reggie could sympathize with Randy's outburst, because he also knew that end-of-the-day feeling all too well. "Let's go and have a few drinks and unwind," Reggie said.

The two pals sauntered over to the bar. The bar was crowded, but that was not unusual; it was always crowded at that time of day. What was unusual was that everyone there was milling around in a state of agitation.

"What's the trouble?" asked Reggie.

"No booze," was the anguished reply.

Randy didn't believe it at first, but it was true. He could not get a drink no matter how hard he tried. Finally, he gave up in frustration; he stormed out of the bar and worked out his anger by going for a long run. Much to his surprise, and the surprise of everyone else, he was able to get a drink when he returned to the bar.

A hush fell over the crowded bar.

"What do you think it means?" asked Reggie.

"I'm not sure," said Randy. "All I know is that I went out and did 50 spins on the wheel and when I came back I got a drink."

The other rats contemplated the significance of this. There was a long moment of silence while they applied their rodent minds to the problem. Regina spoke up first, a quizzical look on her face. "We all did the maze today . . . we always get a drink after we've run the usual rat-race."

"Not today," said Reggie disgustedly, as he sucked unsuccessfully on one of the tiny metal spigots in the bar.

"You can get good cold water over here," shouted Ravina from the other side of the partition. The other rats ignored her. You could always get cold water at the other bar, even if you didn't do the maze. Big deal. What was the fun in that.

The rats returned to contemplating the problem. Once again, Regina broke the silence.

"Let's run around the cage a few times," she suggested, "and see if that'll do the trick."

The rats dutifully scampered around the cage a few times and then rushed expectantly back to the spigots. No dice.

Once again, they applied their rodent brains to the problem.

"I'm going to do me a few spins on that ol' wheel," said Reggie. He stalked out of the bar and the other rats sat in silence, listening to the squeak-squeak-squeak as Reggie worked out on the wheel. And they watched intently when he returned and took a long drag from one of the spigots.

"It's the real thing," Reggie exclaimed. That seemed to settle the question: if you wanted a drink you had to pay more for it. With this realization came anger.

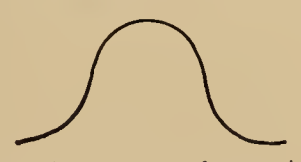
"It's not fair," cried Regina. "I've done my maze and I've a right to my drink; I'm not some mindless wharf rat, I'm a genetically pure albino *rattus norvegicus* and I'll not give up my pleasure because of those two throwbacks."

She did not have to point to the two rats sleeping in the corner. Every rat in the cage knew she was referring to Roland and Rufus, who spent most of their day sucking at the spigots in the bar. Which was just as well, because when they did venture out they always got lost in the maze and it was a pain in the neck for the other rats to have to sally out to find them and shepherd them home.

"What makes you think Roland and Rufus have anything to do with it?" asked Randy.

"It's just a hunch," admitted the exasperated Regina. "Who knows what He is up to?"

At the mention of the word, all the rats cast involuntary eyes upward. Sure enough, they could see two huge blue eyes staring down at them. It was always thus, except when He was preoccupied with his graphs and charts. The rats averted their gaze and whispered among themselves. Maybe He was up to something. They had noticed he had abandoned the bell shaped curves that looked like this:



and was getting more and more involved with strange eccentric curves that looked like this:

But their tiny rodent minds had never made any sense out of the first curve, so it was useless to try to figure out the significance of the second one. Whether it had any foundation behind it was a complete mystery to them. For most of them, even the daily rat-race had no meaning. And so, with a fatalistic shrug of their shoulders, they trooped out of the bar and one by one they took their turn at the wheel. Squeak-squeak-squeak.

A week went by. Most of the rats did their turns on the wheel grudgingly and carried on as before. They didn't like it, but there was nothing they could do about it. Some of them did the wheel when they felt up to it, and joined Ravina in the water bar when they didn't.

And what about Roland and Rufus? Cut off from their favorite beverage, both rats had to make adjustments. Rufus surprised everyone by taking an occasional turn on the wheel. He even started going out to do the maze now and then and — wonder of wonders — his performance increased substantially.

Roland persisted in his intoxicated indolence. How he managed to do it was a mystery, but he did it. (Regina suspected he did it by cajoling the other rats, some of whom were soft-touches, into sharing their hard-earned goodies with him.)

Another week went by, and another 50 spins on the wheel were required. This was, of course, in addition to the everyday rat-race of the maze. A few more rats took to hanging-out at the water bar. Ravina greeted them by saying this was a wise personal choice but that didn't impress them much: they didn't think it was a particularly wise choice, just an expedient one. Midway through that second week Randy claimed he had discovered a loose wire in the cage over by the place where the food pellets were dropped. But the other rats didn't believe him; ever since Rufus and Randy had taken to sniffing the oil that lubricated the wheel the two of them had been coming out with all sorts of fantastic stuff.

Another week went by, and another 50 spins of the wheel were made mandatory. When the rats discovered this they rolled their eyes upward, some in resignation, others in exasperation. They expected to see the omnipresent eyes of what Reggie jokingly referred to as Big Brother Rat staring down at them; but this was one of those rare moments when He was not there. He was hunched over his desk, studiously plotting his new curve on graph paper.

The loose wire made it easy. It was shouldered aside and, in a moment, a host of tiny attackers, a horde of *rattus norvegicus*, was upon him.

He never knew what hit him. After they had eaten him they ate his Ledermann graphs, for good measure.

NEWS

'Lack of control' wins out over time

Controlled drinking fails UK tests

LONDON — While controlled drinking may in theory be possible for some alcoholics, the experience of the great majority of clinicians points to the peril of this approach.

That was the warning handed out by one of Britain's most respected authorities at the World Conference on Alcoholism here.

Max Glatt, consultant psychiatrist at the academic department of mental health, University College Hospital, told the conference there are times when a fortunate constellation of circumstances — absence of stress and favorable social, environmental, and psychological conditions — could mean the individual might get away with a moderate intake of alcohol.

"It is regrettable, however, that it is not possible to know in advance when these fortunate conditions will apply," he said.

Dr Glatt's argument was based on the fact that the "loss of control hypothesis" seems fundamental to the question of whether alcoholics can become moderate drinkers. To a certain extent, he said, some criticism of the abstinence-oriented approach to alcoholism, is based on semantic arguments or a misunderstanding of Jellinek's loss of control concept.

Loss of control does not mean an alcoholic's first drink inevitably and immediately necessitates further drinking. Rather, it means an alcoholic never can be sure he has the ability to stop drinking on a given occasion, once he has taken one or two drinks.

Dr Glatt said that since 1963 he has conducted a trial based on a "gentleman's agreement" with alcoholic patients who refused to undergo treatment based on abstinence. Such patients were allowed to set themselves a daily maximum of alcohol and to proceed on the basis that controlled drinking was possible.

This gentleman's agreement has been adopted by about 300 alcoholics — in the main emotionally fairly stable and highly educated men in their 40s or 50s, usually with a good history of professional achievement.

Although these patients seemed to constitute "a rather promising sample as regards the possibility of controlled drinking," the great majority failed to keep the agreement for more than a few weeks.

By the end of a year, all the alcoholics had failed — some with quite a number of successive failures while requesting "yet another chance" to continue with the trial.

Such observations confirmed that many alcoholics could have a single drink without precipitating a bout of alcoholism — at least not immediately. The Alcoholics Anonymous slogan about the first drink being fatal or disastrous would still apply, however, if one added that the disaster would come "sooner or later."

Dr Glatt argued that his patients demonstrated what he would describe as lack of control rather than absolute loss of control. It would seem that some of them, given insight, a degree of emotional maturity, considerable effort, and luck, could stick to relatively small amounts of drink as long as the going remained good. Sooner or later, however, the required favorable "host" and environmental factors might not pertain.

Dr Glatt concluded that an alcoholic's compulsion to continue drinking need not necessarily, as Jellinek once thought, derive mainly from biochemical processes. The phenomenon is due to a dynamic interaction of factors pertaining to the host, the environment, and the agent.

What seems to be involved is a relative lack of control rather than an absolute loss of control. In practice very few gamma alcoholics can expect to achieve moderate drinking for longer than relatively short periods and the price paid by the drinker, for example by jeopardizing his own health and that of his family, hardly justifies the very risky gamble.

E. Mansell Pattison was correct in stating that abstinence was inadequate alone, but it remains the most likely and reliable means of assisting the alcoholic toward achieving a satisfying, contented, and useful life, he said.

*E.M. Pattison (with others) Critique of Alcoholism Treatment Concepts, New York, Springer, 1977.

Halo effect backfires on drinking MD

TOLEDO, OH — Why does alcoholism occur among physicians at a rate 13 times higher than laymen? It's all part of the "halo effect," the omnipotent feeling among doctors that they are God, says a doctor who knows the route first-hand.

The attitude has profound ramifications.

"God doesn't hurt, he doesn't get sick, or share . . ." says Douglas Talbott, a recovering alcoholic.

Dr Talbott heads the nationally known and highly successful Medical Association of Georgia's Disabled Doctors' Program for physicians with drug and alcohol problems. He was here to speak at a conference on the "revolving door" alcoholic in industry.

Doctors believe "it will never happen to me," Dr Talbott said. Other factors contributing to alcoholism among physicians include:

- Availability of drugs and an alcohol-oriented social life;
- Ignorance about alcoholism because little or nothing has been taught about it in medical schools;
- "Fantastic" stress;
- Being responsible for life and death, and the need to be in "total command," and not to express hurt.

Because of their attitude, doctors may take longer than their patients to admit to having a problem with alcohol, said Dr Talbott.

As a result, he said, the Georgia disabled doctors program involves four months of treatment, rather than the usual 28 days provided for laymen.

The Georgia program includes one month in a rehabilitation centre, one month of outpatient treatment, and two months in what is known as "mirror image therapy." In the final phase, doctors go out into the community and work in free clinics treating other alcoholics.

ARF school extends reach

TORONTO — The School for Addiction Studies (SAS), until now primarily an "in-house" training centre for staff of the Addiction Research Foundation (ARF), has announced a shift in emphasis to appeal to a broader group of professionals in Canada and in other countries.

"Until this year we have chosen subjects for our courses mainly by learning the needs of the ARF staff," Donald Meeks, director of the school told **The Journal.**

"While we will continue to emphasize training courses and programs for foundation staff, some of our new — and also existing — courses are of equal interest to people from other places and organizations."

A four-day course in May, 1982 titled Nursing Management of Addictions, for example, "should interest nurses from any setting where alcohol and drug dependent persons are treated," Dr Meeks said.

Likewise, a February course in relaxation and stress management is aimed at occupational therapists and other clinical personnel.

In July, the school will launch a new summer course in addictions. "This course is modelled after our present Fundamental Concepts course," Dr Meeks said "and will cover the nature of addictions, socio-cultural factors, major approaches to treatment, pharmacological aspects, policy issues, and other aspects of addictions.

"The summer course is aimed at people in any profession or vocation directly concerned with alcohol and other drug problems."

Since 1978, when the SAS began, it has offered 20 courses each year in such areas as basic concepts in addictions; pharmacology and drug abuse; alcohol, other drugs, and the law; basic counselling skills in addictions; group therapy; behavioral interventions; and prevention strategies in the addictions field.

Despite the "in-house" emphasis, even in the first year 25% of admissions were from outside the foundation, said Dr Meeks.

Meeks: shift in emphasis

"We have had participants from a number of provinces in Canada, from the United States, Thailand, Australia, and from several Caribbean countries," he said.

"We haven't done promotionals aimed at audiences outside the foundation, but people have heard about our courses by word of mouth. Communication in our field, even internationally, is quite good."

RESEARCH UPDATE/ Austin Rand

Strokes in habitual drinkers

Thromboembolic or clot-caused strokes occur much earlier in habitual drinkers than in social drinkers or non-drinkers, according to research by L.A. Pearce of Bowman Gray School of Medicine in Winston-Salem, North Carolina. Studying 126 strokes entered in an acute stroke registry, Dr Pearce found the average age at which clot-caused strokes occurred among habitual drinkers was 53 years, compared with 62 for social drinkers and 69 for non-drinkers. "Onset of stroke peaks in the 70s for non-drinkers, in the 60s for social drinkers and in the 40s and 50s in the habitual drinkers," says Dr Pearce. These results, he notes, support data recently reported in *Lancet* suggesting that acute ethanol intoxication promotes brain infarction in young adults. *Paper presented at the American Academy of Neurology*, Annual Meeting, Toronto, 1981.

Decaffeinated heartburn

Decaffeinated coffee is a potent stimulator of gastric secretions and as little as half a cup can produce dyspepsia and heartburn, say researchers at University of California, Los Angeles, School of Medicine and the Center for Ulcer Research and Education at Wadsworth Hospital Center, CA. They compared decaffeinated coffee's ability to produce gastric secretions against the effects of a standard protein meal, called Bacto-peptone. "On a weight-for-weight basis, no stronger intragastric stimulant of gastric secretion and gastrin release than peptone had hitherto been identified. On the basis of the present study, decaffeinated coffee appears to be the most potent intragastric stimulant of acid secretion and gastrin release identified to date." The precise chemical agent producing the effect has not yet been identified, the researchers say.
JAMA, 1981, v. 246: 248-250

Framingham criticized

It is a mistake to interpret data from the Framingham study as indicating that filter and plain cigarettes are associated with an equal risk of coronary heart disease (CHD), says Peter Lee. He's author of a recent study showing, on the basis of more than 10,600 deaths, a 10% to 20% lower CHD mortality in smokers of filter cigarettes (*J. of Epidemiology & Community Health*, 1981, v. 35: 16-22). Dr Lee says the Framingham data, which include only 60 CHD deaths to date, are too limited to bring out the relationships that actually exist between type of cigarette smoked and CHD incidents and mortality. In the Framingham data, even the 22% reduced CHD mortality of nonsmokers compared to smokers does not come out as significant, he says. "Far more emphasis should have been placed on the limitations of the Framingham study data. The findings do not provide reliable evidence on which to doubt the benefits of the switch from plain to filter cigarettes." Responding, William Castelli says a 25% decrease in lung cancer rates in filter smokers "means in practical terms that a pack a day smoker of cigarettes goes from 20 times the risk of lung cancer with plain cigarettes to 15 times the risk with filter cigarettes. I do not personally get much satisfaction encouraging someone to pursue a habit which increases the risk of lung cancer 15 times." Dr Castelli says attention should be given to "the number of people (addicts) who have rationalized their health away because they want to believe the propaganda that a safe cigarette is on the way."
Lancet, 1981, v. 2: 642

Quitters feel vulnerable

Ex-smokers, moderate smokers (up to 10 cigarettes daily), and heavy smokers (more than 10 cigarettes daily) differ in their beliefs about the effects of smoking, both general and personal, a study indicates. Ex-smokers saw smoking as having adverse effects, and saw themselves as personally susceptible to those effects. Moderate smokers allowed there were adverse effects, as a rule, but saw themselves as being not very affected. Heavy smokers were less likely to grant that smoking had ill effects on health and saw themselves as unaffected. "In order to quit," the researchers concluded, "it is not sufficient for persons to believe smoking is a serious health problem; they also must see themselves as personally susceptible to any adverse affects." The researchers suggest stop-smoking programs should try to alert smokers to evidence of personal vulnerability. They said subjects in the study considered that written information on the health effects of smoking had little impact.
Am J Public Health, 1981, v. 71: 1253-1255

New hangover antidote?

Oil from the seed of the evening primrose may be a powerful antidote for hangover, says David Horrobin. He says the efficacy of the oil, available in capsule form from health food stores and pharmacies, lies in the fact it is a source of gamma-linolenic acid, a precursor of prostaglandin E1, a hormone-like substance with multiple regulatory functions. The production of gamma-linolenic acid (GLA) from its precursor, the commonly available oil called linoleic acid, is blocked in the body by alcohol. Other than GLA produced in the body, very little is available; only evening primrose oil and human milk contain substantial amounts. Citing both animal and human studies suggesting GLA is likely to be an effective addition to treatment of acute withdrawal, Dr Horrobin says: "In about 15 normal individuals liable to develop severe hangovers after a bout of heavy drinking, and in five alcoholics, I and colleagues have found that GLA can largely abolish withdrawal symptoms."
Medical Hypotheses, 1980, v. 6: 929-942

NEWS AND COMMENT

Researcher reports on dangers of new fad

Oral tobacco ups heart rate, blood pressure

By Barbara Baker

DALLAS — Sucking on a pinch of smokeless tobacco, a growing fad among young people, can produce significant hemodynamic changes and may have particularly harmful effects on those with a hypertensive predisposition.

The warning comes from William Squires, associate professor of biology at Texas Lutheran College in Seguin, Texas.

In what he says is the first controlled research project on the impact of oral tobacco, or snuff, on the cardiovascular system, Dr Squires and his colleagues found the nicotine it contained significantly drove up blood pressure and increased heart rate.

Users "don't get the lung involvement they do with cigarettes, but long term use of the product might have some deleterious effects on high blood pressure," he said in an interview here at the annual meeting of the American Heart Association.

The hemodynamic effects of the smokeless tobacco, "are relatively similar to ordinary smoking tobacco," he said. "But there's probably more nicotine content in the smokeless product than in a cigarette, depending on the brand."

He said the nicotine contained in the smokeless variety was about 20 times more potent than that contained in a low tar and nicotine cigarette.

It has been estimated that there are 22 million users of oral tobacco in the United States, Dr Squires said. In Canada, the fad is growing, with a 4% to 5% annual increase in sales.

Dr Squires said the product, advertised heavily in the US by "macho football players," is placed in the front of the mouth, between the lip and the gum. It's neither sniffed, nor chewed; nicotine absorption takes place through oral mucosa.

For his research, Dr Squires recruited 20 student male athletes, aged 20, half of whom were regular oral tobacco users.

All abstained from any tobacco use for 72 hours, at which time baseline electrocardiograms and blood pressure measurements were taken.

"We put into their mouths a normal dose of oral tobacco, about 2.5 gms, equal to a tablespoonful, or what students call 'a good healthy, man-size dip,' " he said.

Within 20 minutes, heart rates increased to an average of 88 beats a minute from 69. Average blood pressure values increased to 126/78 from 118/72 mmHg.

Dr Squires said these values soon returned to normal in all the students when the bolus of tobacco was removed.

Dr Squires' co-authors at Baylor College of Medicine in Houston were Ted Brandon, Dr Tinker Murray, Steve Zinkgraf, Douglas Bonds and Dr Richard Miller.

Cannabis report en route to UN

TORONTO — The most up-to-date findings on the effects of marijuana on health and behavior will be presented to the United Nations Commission on Narcotic Drugs next month in Vienna.

The report* is a summary of papers and discussions by 26 international experts, both clinicians and experimental scientists, who participated in a conference sponsored by the World Health Organization (WHO) and the Addiction Research Foundation of Ontario (ARF) in April, 1981.

Aimed primarily at government, especially ministries of health, and at physicans, the report summarizes the effects of cannabis on cardiovascular and respiratory functioning, on the immune system, the endocrine system (including reproduction and sexual behavior), on the nervous system (including driving skills and prenatal exposure), epidemiological research, sex differences in cannabis effects, physical or psychological dependency, and experimental methods in studying cannabis.

"The report is not only a summary of what is known, but it's also very interpretive," Kevin Fehr, one of the organizers of the ARF-WHO conference and one of the editors of the report, told **The Journal**.

"It explains the difficulties in studying a drug of this nature — why certain things about cannabis can be said with confidence and why other things are tentative."

**The Adverse Health and Behavioral Consequences of Cannabis Use*, published by the Addiction Research Foundation, Toronto.

GILBERT

"Ethics committees... have a very difficult job."

Experimenting with humans

By Richard Gilbert

When I began doing research my subjects were rats. The kinds of things you can do with animals in the name of science were very restricted in Britain. Stiff legislation was enforced by a corps of inspectors recruited, it seemed, from the ranks of retired army physicians who had spent their best years in colonial outposts. The inspectors were watched by the ever-vigilant Royal Society for the Prevention of Cruelty to Animals, whose members believed that all experiments on animals were cruel. (Unethical was too dull an epithet.)

My colleagues who used human subjects suffered no such constraint. They could get away with almost anything short of a criminal act.

In Ontario, thankfully, things are different. Research on animals is regulated. Apparent discomfort may be caused them only with strong justification. But the real stringency is reserved for work on human subjects. Procedures are scrutinized to ensure that they are useful, relatively harmless, and perpetrated with the informed consent of the subjects.

Two-stage review

Normally the scrutiny for ethical acceptability is conducted after there has been assessment of the scientific merits of a research proposal. Thus, at the Addiction Research Foundation (ARF) and in other institutions where research on human subjects occurs, there is a formal, two-stage review process that should apply to every piece of proposed research. As I noted last month, the scientific review has ethical implications that are often neglected. When a research project is improperly designed, subjects may be exposed to unjustified risk and inconvenience, resources may be misused, and unnecessary further work may be instigated.

Thus the primary function of the scientific review is to protect the scientific community by preventing the intrusion of useless or even harmful data. The scientific review committee's job is analogous to an agricultural products inspector who is charged with preventing the passage of substandard or infected produce. The second function of the scientific review is to protect the community at large that would have to bear the cost of poor research. The third function is to protect the potential subjects of the proposed work, so that they are not subjected to risk without reasonable cause.

But the real business of protecting subjects occurs during the second stage — the ethical review. A research proposal may be scientifically sound in that it offers the promise of a useful increment in our understanding of the world, and yet it may include unethical procedures. Subjects may be harmed unduly, deceived unreasonably, or rewarded excessively as an inducement to participate. Ethical review committees should reject research in which these things might happen.

Moral considerations

The guidelines employed by ethical review committees are based on numerous influential statements to the effect that moral considerations must have a central place in the quest for knowledge.

The first of these came from the Greek physician Hippocrates, who died some 23 centuries ago. He said of medicine that "Life is short, and the Art long; opportunity fleeting; experiment dangerous, and judgement difficult."

A more recent statement was the Nuremberg Code of Ethics in Medical Research, drafted in 1947 as a result of the horrifying evidence presented during the trials of certain war criminals. The first four articles of this code address, respectively, the requirements that subjects participate voluntarily, that the procedures are necessary, that the study will be fruitful, and that the design is such as to avoid undue suffering.

The fifth article reads as follows: "No experiment shall be conducted where there is an *a priori* reason to believe that death or disabling injury will occur: except, perhaps, in those experiments where the experimental physicians also serve as subjects." The remaining five articles of the Code provide amplification of this point.

Ethics committees, as can be imagined, have a very difficult job. However carefully guidelines are written, the final conclusions must be matters of collective judgement, not the automatic application of rules. Thus it is not surprising that there can be profound disagreement with the decisions of ethics committees. I would like to discuss briefly two recent decisions that I disagree with. They illustrate some of the problems faced by researchers, ethics committees, and the community at large in dealing with these difficult issues. Neither case involved me directly.

Two cases

The first of these cases was before ARF's ethics committee on many occasions in 1980 and 1981. The object of the study was to examine the relation between alcohol consumption and certain measures of liver function. The controversial procedure was the administration of up to six alcoholic drinks a day for 14 days to "normal" subjects who were other ARF scientists. The experimenters believed this procedure involved no risk if proper precautions were taken. The committee disputed this. The experimenters rejoined by proposing to include the subjects as legitimate co-investigators. The committee did not relent, arguing that the principles and concerns respecting self-experimentation should be the same as those that apply to the general use of human subjects.

I think the committee was wrong because it ignored the specific exception allowed in the Nuremberg Code. It is unclear why the committee did not acknowledge the exception. A sense can be gained from the minutes of the committee that there was fear for the reputation of ARF if word got around that drunken scientists were living it up at 33 Russell Street. But the primary role of the committee is to protect subjects, not the institution that sponsors the research.

Self-experimentation

Scientists who have furthered science by trying out necessary but potentially hazardous procedures upon themselves have an honorable and important place in our history. J. B. S. Haldane told us much about the toxic effects of deep-sea diving in this way. Apart from ensuring that all necessary precautions are taken, ethics committees should not interfere with this noble and useful tradition.

My other case, by contrast, involves a study that was approved (by a University of Toronto ethics committee) even though there was admitted mortal risk to subjects who were not experimenting upon themselves. I am referring to the breast cancer screening program currently under way and sponsored by the National Cancer Institute of Canada. In the course of the study, 45,000 women aged 40 to 49 are to be given an X-ray mammogram once a year for five years. The objective of the study is to discover whether screening for breast cancer is useful for apparently healthy women of this age.

X-rays can cause breast cancer, as well as detect it. There are various estimates of how many of the 45,000 women will contract breast cancer and possibly die as a result of being in the study. Even the director of the study admitted before Toronto's Board of Health in January 1980 that there is "a 50-50 chance that at least one healthy woman given an X-ray in the proposed program will, as a consequence, develop cancer that she would not otherwise have."

There are also estimates of the number of cancers that will be detected by the program at a sufficiently early stage to effect a cure, cancers that would otherwise not be detected at that stage. Almost everyone agrees (including me) that more lives might be saved than lost as a result of the study.

But, notwithstanding this cost-benefit analysis, it seems clear to me that the breast-cancer screening study is in contravention of Article 5 of the Nuremberg Code. It should not have been approved.

Unethical recruitment

I have another objection to this study. Last summer it was discovered that women were being recruited into it by their physicans. The physicians were not the experimenters, but they were asked by the experimenters to recruit subjects. This comes close to violation of the University of Toronto's Guidelines on the Use of Human Subjects, which say that "a physician should not in principle use his or her own patients as subjects of experimentation" and that "a physician will not be allowed to exploit convenient access to his or her own patients."

Research is a difficult enough job at the best of times, and the justifiably growing concern for the welfare of human subjects is not making life easier for investigators. Ethics committees are the guardians of the public interest in this matter. As they become more experienced, there will be less cause for complaint about the important decisions that they make on our behalf. The practice of science is one small aspect of the human condition. It must be firmly reconciled with our notions of human welfare and dignity.

Next month: Is drinking and driving really a problem?

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The Journal

Published by Addiction Research Foundation of Ontario
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Ramsey writes to Canada's health minister

CAF chief urges cannabis caution

Following is a copy of a "presidential statement" on marijuana from Ross Ramsey, president of the Canadian Addictions Foundation, to Monique Begin, Canada's minister of health and welfare. Mr Ramsey, also assistant executive director of the Alcoholism Foundation of Manitoba, told **The Journal** *the CAF intends to poll members on the question of marijuana legislation: "However, I felt that some statement should be made on this issue by the president of CAF at this time and have, therefore, elected to do it by way of a presidential statement."*

The Honourable Monique Begin
Minister, Health & Welfare Canada
House of Commons
Ottawa, Ontario

Dear Madam:
On behalf of the Canadian Addictions Foundation, I wish to express concern regarding the proposed legislative changes relating to cannabis.

I understand the impact current legislation has upon those persons subject to the severe penalties sometimes imposed for use and possession of cannabis. Adverse consequences for the individual may include limitations on participation in professional careers, difficulty in travelling across international borders, as well as negative impact upon one's own self worth and esteem.

While recognizing there may be merit in changing the legislation to foster a compassionate and humanitarian approach in dealing with offenders, I am also aware a change in legislation could result in the public developing a more casual view toward the use of cannabis, thereby increasing availability and use of the substance. It is for these reasons that I favor legislation where possession of cannabis in any form remains a punishable offence.

Notwithstanding the present debate and the plethora of legislative options, there is increasing research evidence of health hazards associated with the use of cannabis. I wish therefore to recommend that a major ongoing public education program be undertaken by the federal government:

- to alert Canadians to the adverse effects of cannabis use upon mental and physical health;
- to emphasize safety risks associated with its use;
- and, to discourage use by detailing potential consequences to users.

While the target population of this campaign would be all Canadians, special consideration should be given to children and adolescents who represent the sector of our population with the highest incidence of use.

Finally, I would note the real need for continuing research in this area, not only of a bio-medical nature, but to measure the social and attitudinal impact resulting from any changes in the current legislation.

The Canadian Addictions Foundation is prepared to offer its assistance in these tasks and to work closely with the federal government in the development and delivery of a program aimed at counteracting the use and abuse of cannabis.

I would be happy to discuss this further with your officials. In the meantime, I look forward to your response.

G. Ross Ramsey, MSW
President
Canadian Addictions Foundation

Ephedrine gives Thais trouble

Amphetamine is widely used in Thailand as a stimulant, especially by truck drivers, food vendors, and students cramming for examination. Since 1978, we have imposed strong control on importation and raised the penalties; the drug has become rather hard to get.

So, in 1980, police found that what was being pushed as amphetamine was actually more than 50% ephedrine. In 1981, the percentage of ephedrine had risen to 90%.

Addicts report they received the same stimulating effect from the new product, but to a lesser degree.

Ephedrine 15-60 mg orally stimulates both the central nervous system and peripheral nervous system, causing vasoconstriction, raising blood pressure, and dilating the spastic bronchi. Hence it's a useful medication for asthma. Some find it useful in narcolepsy.

Ephedrine, however, may be the next drug of concern in the war against addiction.

Col. Aroon Shoawanasai, MD
Chief, department of psychiatry
Phra Mongkutklao Army General Hopsital
Bangkok
Thailand

Watching

We enjoy very much receiving **The Journal**.

We believe the information on drug abuse in **The Journal** is likely the best we can obtain in the country. Especially we appreciate the way you treat all forms of drug abuse, including abuses of tobacco and alcohol.

More and more the Biblical exhortations to complete abstinence, in some cases, and moderation in others, are proving to have been both wise and practical, and not unduly restrictive after all.

Again, thank you for your good research and well-presented material.

Eugene Rosam
Information Officer
Watch Tower
Georgetown, Ont

Budget ills

Due to a cut in our operating budget, and prospects that the situation will not improve soon, we regret to inform you that we will be unable to renew our subscription to **The Journal**. Therefore, will you please remove our name from your subscription list.

The Journal has been a useful source of information in our work with youth (and adults), and we thank you for your courtesies to us over the past several years.

Eva D. Sonshil, Secretary
Needham Youth Commission
Needham, MA

The Journal welcomes Letters to the Editor. Send your letter to The Editor, **The Journal**, 33 Russell Street, Toronto, Ontario M5S 2S1.


AND A
HAPPY
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1982
The Journal

SKUNKS ARE BORN

10th MAY

AUG 29-SEPT 1 WASHINGTON D.C

"CUT!"

ADDICTION BUDGET

A.D.P.A.N.A

FIRST BUILT-IN BATHTUB INSTALLED DEC 20 1842

JULY 5-9 MUNICH

VE HAF VAYS OF MAKING THEM ABSTAIN!

28th U.P.T.A

MAY. EAGLEVILLE HOSPITAL CONFERENCE

AND, UH-WHICH HOSPITAL DO YOU REPRESENT?

KING of PRUSSIA PENN.

APRIL WASHINGTON D.C

NO MISTER HAIG, WE WONT BEAT ALCOHOLISM BY BOMBING 'EM ALL TO HELL!

N.C.A

NEVER LET YOUR DING DONGS DANGLE IN THE DIRT

MARCH 30-APRIL 4 OXFORD, ENGLAND

I SHAY- SHALL WE JOIN THE LADIESH?

NOVEMBER. PHILADELPHIA

THE CITY OF BROTHERLY LOVE, BUSTER!

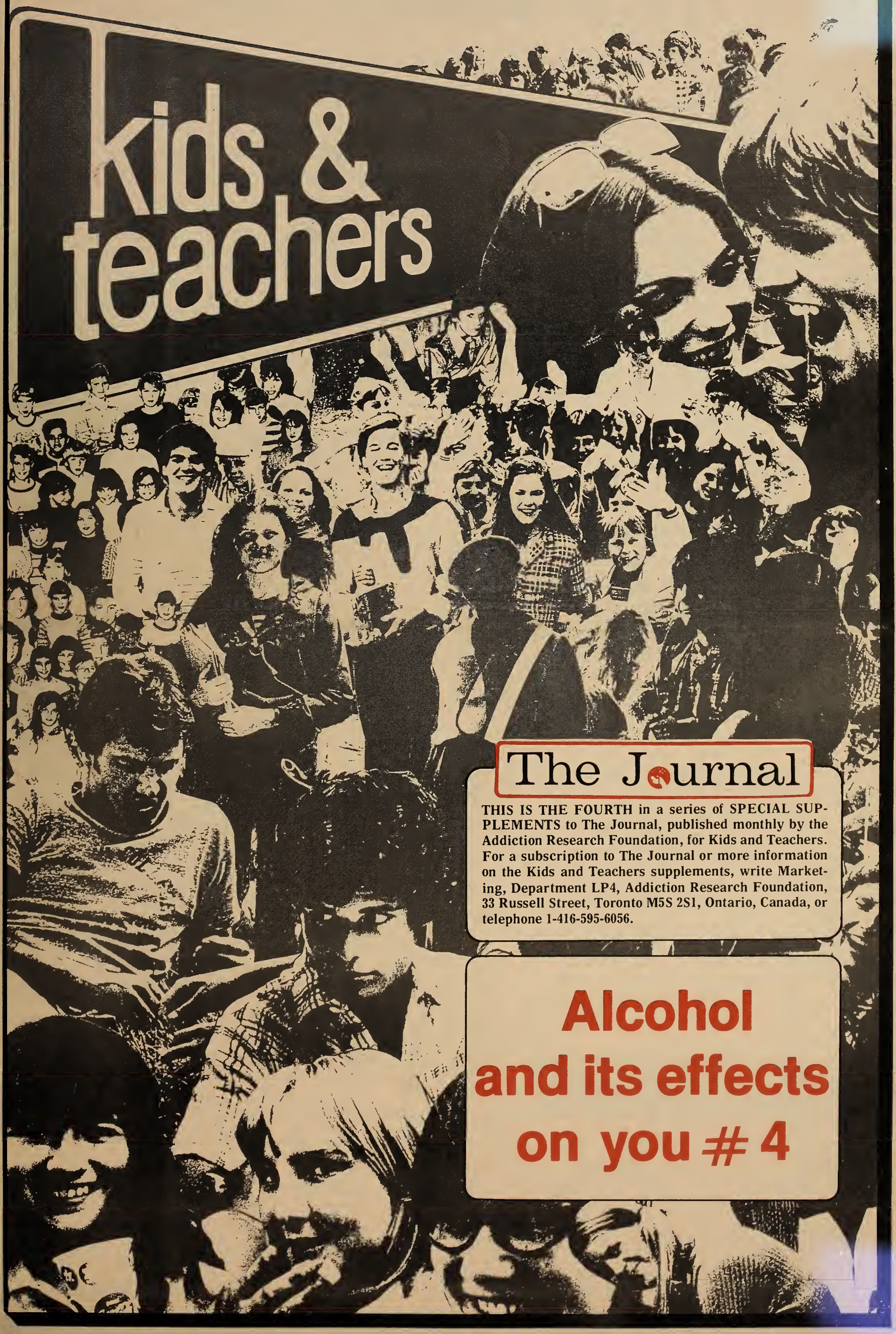
A.L.M.A.C.A

OCTOBER 9-15 MOROCCO

WELL, YOU ASKED HOW DO WE GET HIGH IN TANGIER

I.C.A.D.D.

kids & teachers



The Journal

THIS IS THE FOURTH in a series of SPECIAL SUPPLEMENTS to The Journal, published monthly by the Addiction Research Foundation, for Kids and Teachers. For a subscription to The Journal or more information on the Kids and Teachers supplements, write Marketing, Department LP4, Addiction Research Foundation, 33 Russell Street, Toronto M5S 2S1, Ontario, Canada, or telephone 1-416-595-6056.

Alcohol and its effects on you # 4

kids & teachers

YOU ASKED US. . .

Dear Karen,
When my friends and I drink together, I always end up getting drunk and they don't. We all drink the same amount — usually gin or rye. Even when we drink only beer or wine, I get the drunkest. Why does this happen to me? **— Why Me?**

Dear Why Me,
I'd like to clear up a common misconception right away — wine, beer, and spirits all contain the same ingredient — absolute alcohol. It's this absolute alcohol that makes you drunk. Beer and wine are *not* less problematic than spirits. The absolute alcohol in one 12 oz bottle of beer equals that in a 5 oz glass of wine, 1½ oz spirits, 24 oz the lightest beers, or 7½ oz malt liquor beer.

The degree of intoxication, or drunkenness, varies with each individual depending on:

- the amount you drink
- over what period of time you drink
- sex
- body weight
- body type (fat, lean)
- body's metabolic rate
- experience with drinking
- the presence of other drugs in your system

If you drink the same amount as your friends, but over a shorter period of time, you could become drunker. If you are female, weigh less than your friends, and have a higher body fat content, you could also get drunk more quickly.

Alcohol is metabolized (broken down) by the liver at a constant rate. Individual rates vary from 1.4 to 1.9 hours per drink — maybe you have a slower metabolic rate. If your friends drink more often than you, perhaps they have become tolerant to the effects of the alcohol so they need to drink more to experience the effect they used to.

Finally, if you are taking over-the-counter, prescription, or illicit drugs, and drinking, you may multiply the alcohol effect, and feel more intoxicated than your friends.

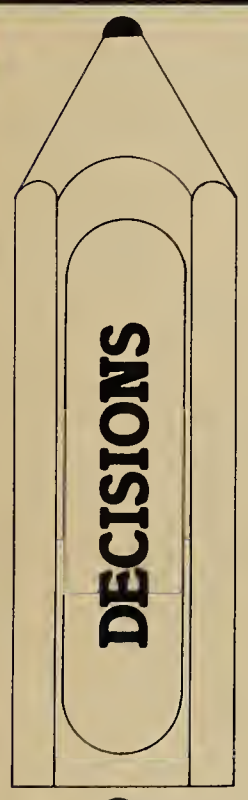
Is there something you want to know about drugs? Karen Girling answers a lot of questions from students and teachers in her job as information specialist at the Addiction Research Foundation. Why not ask her? Write Karen, c/o *Kids and Teachers*, The Journal, Addiction Research Foundation, 33 Russell St., Toronto, M5S 2S1 Ontario, Canada. Names will be withheld.

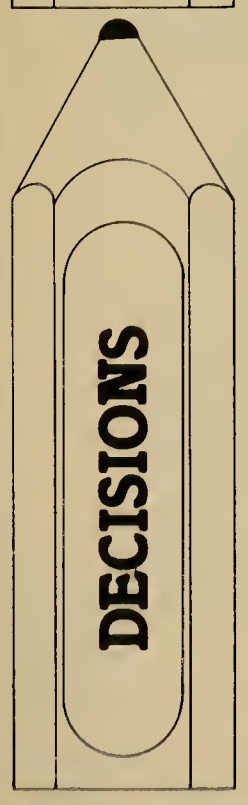
Dear Karen,
My dad is on a diet. He says he wants to lose 60 pounds. He has cut out all sweets and breads, but he still drinks beer. My health teacher said beer is fattening. My dad says it is a healthy food. I think my teacher is right. How do I tell my dad? He needs to lose weight. **— Concerned Daughter**

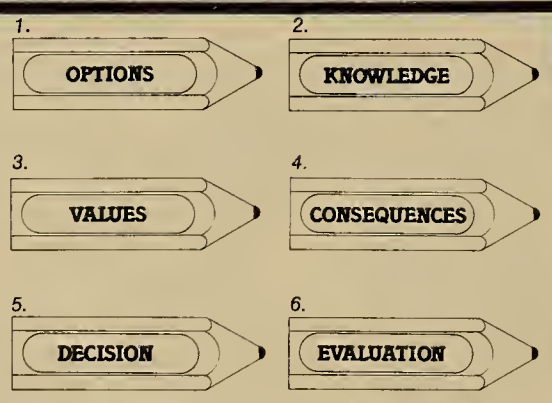
Dear Concerned Daughter,
Alcohol (in beer, wine, and liquor) contains none of the vitamins, minerals, or amino acids essential to the daily diet, but it can make you fat! For example:

12 oz (341 ml) beer	= 173 calories
1½ oz (43 ml) gin	= 107 calories
1½ oz (43 ml) rum	= 107 calories
1½ oz (43 ml) whisky	= 107 calories
3 oz (85 ml) port	= 160 calories
3 oz (85 ml) sherry	= 170 calories

Two beers contain more calories than a piece of pie or a cream puff. Maybe you or another family member can speak to your father about his diet. I would suspect he is not following a doctor's diet although he should, considering the amount of weight he wants to lose. Encourage him to see a doctor for a healthy diet plan, which may include the beer he enjoys, but will provide him with essential nutrition too.







One thing about liquor — it sure chased the worries. Ever since his court appearance, Bill just had to have the odd one to steady his nerves. Fortunately, because he was young and had no previous convictions, he pulled through.

Still he felt so edgy and his father's attitude seemed so distant. "I wonder what he'd do if he knew I raided his liquor cabinet?" Bill wondered.

Hey that was a thought. Maybe he could sell a bottle or two as well. There were loads of kids in grade nine who'd jump at the chance, and Bill could make a tidy profit. Just take a little Scotch from each of his dad's bottles and water it down and he'd be in business. The worst that could happen would be . . . well, best not to think about it. What was life without risks? And what did they expect kids his age to do? Go bowling? Grownups were so hypocritical. Always quick with the advice, but they sure liked the sauce themselves.

A few days later, Bill stashed a mickey inside his gym bag in his locker. He was looking forward to the payoff at lunch and an easy twenty bucks.

* * *

(1) "What was life without risks?" Do you agree some danger or excitement is needed to enjoy life?
(2) "Grownups were so hypocritical. Always quick with the advice, but they sure liked the sauce themselves." Do you agree with Bill? Why do you think grownups are sometimes hypocritical about this issue?
(3) Use the decision-making model introduced in the first issue of **Kids and Teachers** (October, 1981), and summed up above, to assess Bill's decision to sell his father's liquor to the kids at school.

THE KIDS ON HIGH ST.

featuring Al Ked

CROSSWORD

Across
1. How you may feel after six or seven drinks (9)
5. Having an _____ drink won't make you sick (10)
8. Sometimes the color of a person's face turns _____ after a drink (3)
9. Person who takes drugs (4)
12. Your ability to _____ clearly may be impaired after several drinks (4)
14. To avoid the unpleasant effects of alcohol, it's good to know when to _____ (4)
17. The _____ of THC in the body from marijuana smoke means that the more often a person smokes, the less marijuana he needs to get high (12)
18. Ability to _____ to emergency situations decreases with every drink (5)
22. After two or three drinks, your speech may _____ down (4)
23. Your ability to _____ in focus may be impaired after several drinks (3)
25. A means of transportation other than a car (3)
26. How your hands and feet may feel after a few drinks (4)
28. What not to do when drunk (5)
29. Your physical _____ will be poor after several drinks (12)
32. What to ask for when you have a problem you can't solve yourself (4)
34. After too much to drink, you may become clumsy and _____ or fall easily (4)
36. How your body temperature feels after two or three drinks (4)
39. Main mood-altering ingredient in cannabis (3)
40. Some people drink alcohol to gain _____ among peers (10)
41. Regular use of alcohol creates physical _____, which means that larger doses are necessary to produce the same effects (9)

Down
1. Some people want to drink when they feel _____ in a social situation (7)
2. If you _____, the effect of alcohol you drink will be delayed (3)
3. Alternative to (25) Across (4)
4. Inebriated (5)
5. Heart action speeds up after just _____ drink (3)
6. What you may want to do after two or three drinks (5)
7. Your inhibitions may be _____ after one drink (7)
10. Several drinks will _____ your speech, hearing, and physical coordination (6)
11. Alcohol is absorbed directly into our bloodstreams from our intestines, with a small amount absorbed by our _____ (plural) (8)
13. People sometimes drink in order to feel more _____ (7)
15. Severe or _____ alcohol poisoning can cause unconsciousness or death (5)
16. How you may feel after a few drinks (similar to (6) Down) (6)
19. Things may look like a _____ after too many drinks (4)
20. Incidence of lung _____ is higher in smokers than non-smokers (6)
21. The only cure for intoxication (4)
23. Some people feel it is not _____ for parents to serve liquor to their children (8)
24. Several drinks may _____ quick reactions (7)
25. Since a larger person has more _____, alcohol is more diluted when it reaches the brain (5)
27. If you have a lot to drink, you may later _____ what you said or did while drunk (6)
30. It is wise not to drive any _____ when drunk (7)
31. Consumption of alcohol is widely portrayed in the _____ (5)
32. This body organ speeds up when you smoke, but slows down when you've had several drinks (5)
33. It's good to know your _____ when drinking (5)
35. Drinking heavily over a long period of time can _____ brain cells (4)
37. Past tense of (2) Down (3)
38. Approximately four ounces of this substance can be deposited annually in the lungs of a 20-cigarette-a-day smoker (3)

. . . WE ASKED YOU

kids & teachers

What pleasant effects on their bodies and minds do you think kids are looking for when they drink? What negative effects do you think kids dislike?

Peter, 15:

People want to be friendly, relaxed, and carefree. On the negative side are: being sick, hangovers, the possibility of police, and feeling paranoid later.

Doug, 16:

Kids want to lose their inhibitions, to say anything to anyone, to go all out. Everybody's afraid, though, of getting sick and burning out brain cells. I think that other people, when drunk, look ridiculous — they humiliate themselves.

Janice, 16:

Kids drink to have a good time and because their friends do it. They like to feel light, carefree, without worries. They dislike the after-effects, such as getting sick. Kids also worry about how they acted while intoxicated because they don't remember.

Mary and Brent will be asking other teenagers questions each month for Kids and Teachers. If you have a question you'd like Mary and Brent to ask, send it to them at: Kids and Teachers, c/o The Journal, 33 Russell St, Toronto M5S 2S1, Ontario.


Peter, 17:

A lot of people drink to be accepted by their friends. They like the dizziness and lack of inhibitions and feeling older than they really are. They dislike the hungover feeling from drinking too much the night before. Young kids feel guilty about drinking but don't admit it to their peers.

Eric, 18:

I think they like the euphoric high that it gives them. They like to have something else in control. They use it as an escape. They like to stumble around and feel dizzy. They dislike feeling tired in the morning and also getting sick when they overdrink.

Adele, 16:

The pleasant effects that motivate people to drink are feelings of freedom; often when you drink you have no inhibitions or shyness. You also may lose control over your actions, and people seem to enjoy that. The negative effects of alcohol are that many times it acts as a depressant. Often people drink to alleviate their problems, and when this doesn't happen they just drink more. They get even more depressed and their problems seem to get worse.

Tanya, 17:

I think a lot of kids just like the taste of alcohol. No one wants to have a hangover, or to screw up her mind using alcohol as an escapism.

Pierette, 16:

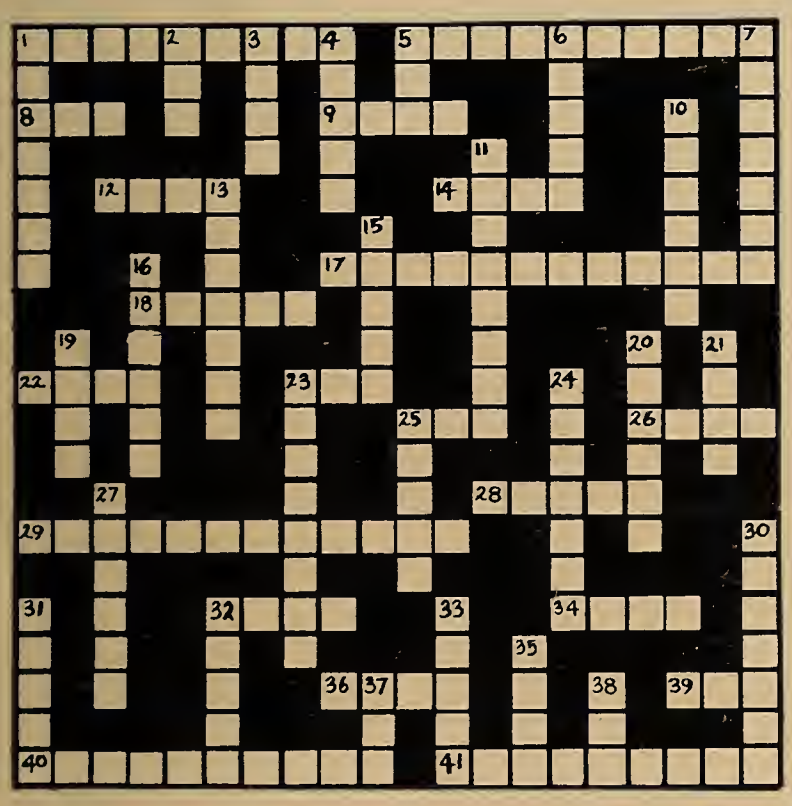
There aren't too many. Most just want to be relaxed and more comfortable. Kids worry about drinking too much, being sick, and humiliating themselves. Some kids drink too much and too often. It affects them when they get older — there's not much pressure now, but there will be more later on in life.

Did you know?

- The tar content of cannabis smoke is at least 50% higher than that of tobacco. Heavy cannabis users therefore run an added risk of lung cancer, chronic bronchitis, and other lung disease.
- Nicotine is an extremely toxic substance . . . two or three drops of the pure alkaloid on the tongue will rapidly kill an adult. A 19th century Belgian, Count Bocarmé, killed his brother-in-law this way.
- Short term effects of smoking include an increase in heart rate, a rise in blood pressure, and a drop in skin temperature.

Editorial team: Anne MacLennan, editor; Greg Arbuthnot, design; Evelyn Cluer, cartoons and crossword; Jerrine Craig, production; Susan Lawrence, editorial consultant; Sharon MacLennan, graphics; Marg Sheppard, education consultant. Columns by Paul C. Brown, Karen Girling, Brent Poulton, and Mary Schankula.

Answers to True and False on page S4 — Surprise, they're all true!



Across
1. NAUSEATED, 5. OCCASIONAL, 8. RED, 9. USER, 12. HEAR, 14. STOP, 17. ACCUMULATION, 18. REACT, 22. SLOW, 23. SEE, 25. BUS, 26. NUMB, 28. DRIVE, 29. COORDINATION, 32. HELP, 34. TRIP, 36. WARM, 39. THC, 40. ACCEPTANCE, 41. TOLERANCE.

Down
1. NERVOUS, 2. EAT, 3. TAXI, 4. DRUNK, 5. ONE, 6. SLEEP, 7. LOWERED, 10. IMPAIR, 11. STOMACHS, 13. RELAXED, 15. ACUTE, 16. DROWSY, 19. BLUR, 20. CANCER, 21. TIME, 23. SUITABLE, 24. INHIBIT, 25. BLOOD, 27. FORGET, 30. VEHICLE, 31. MEDIA, 32. HEART, 33. LIMIT, 35. KILL, 37. ATE, 38. TAR.

ASK YOURSELF

The ABCs of Safe Drug Use

On the list below, check those drugs you have used. Have you ever used two or more of these drugs at the same time?

alcohol	☐
antihistamines	☐
marijuana	☐
ASA	☐
laxatives	☐
codeine	☐
iron tablets	☐
antacids	☐
motion sickness pills	☐
sleeping pills	☐
barbiturates	☐
amphetamines	☐
antibiotics	☐
sedatives	☐
tranquillizers	☐
cold remedies	☐
caffeine	☐
antidepressants	☐
LSD	☐
PCP	☐
cocaine	☐
glue/solvents	☐
tobacco	☐
hash	☐
hash oil	☐

You may not even realize you are using two or more drugs/substances at the same time. Since some drugs remain active in the body for several hours, or even days, that pill you took yesterday could still interact with alcohol you drink today.

By itself, a drug can be medically useful, but adding one and one when using drugs doesn't necessarily equal two. It could equal three or four, or more. Remember . . . alcohol is a drug, too.

Health and Welfare Canada has identified some dangerous drug combinations.

THIS + THIS = THIS

Alcohol	antidepressants	increased alcohol effects
Alcohol	antihistamines	increased alcohol effects, depression, dizziness
Alcohol	pain relievers	bleeding in the stomach or intestines
Alcohol	sedatives	increased sedative effects, depression
Alcohol	sleeping pills	dangerously depressed respiration, possible death
Alcohol	tranquillizers	increased sedative effects, depression, dizziness
Antibiotics	antacids	decreased antibiotic effects
Antibiotics	sedatives	increased sedative effects
Antidepressants	antihistamines	increased antihistamine effects, dizziness
Antidepressants	cold remedies	drastically increased blood pressure
Antidepressants	sedatives	increased sedative effects
Pain relievers	sleeping pills	dangerously increased drowsiness
Sedatives	antihistamines	increased sedative effects, decreased antihistamine effects
Sedatives	tranquillizers	dangerously increased sedative effects

To avoid dangerous drug interactions:

Ask your pharmacist or physician

Before you mix medications or alcohol and

Check all drug packaging labels for precautions and dangerous side effects.

kids & teachers

Alcohol and its effects on you: *physical, behavioral, and psychological*

Teacher Objective
To explore the physical, behavioral, and psychological effects of drinking alcohol.

Student Objective
To understand the physical, behavioral, and psychological effects of alcohol on young people.

Step 1
Show a series of pictures of people in different drinking situations, for example, advertisements for alcohol. Material collected in Lesson 3 (Alcohol and the Media) can be used here.

Ask: **In each example, what effect do you think the drinker wants?**

To feel better, to feel more comfortable, to feel more sociable, to feel less tense, to relax, etc.

Step 2
Ask: **What part of your body controls the way you act and feel?**

The brain

Ask: **How does alcohol get to the brain?**

Once it is drunk, alcohol is absorbed directly into the bloodstream from the intestines, with a small amount absorbed from the stomach. It is carried in the bloodstream throughout the body to every organ including the brain — the part that triggers the effects you feel.

Step 3
Ask: **What do you think are the effects on your body of one drink? Of two drinks? Of five or six drinks?**

Develop with the students a chart like the one illustrated, drawing on their knowledge. When they've filled in as much as they can, hand out individual **Kids and Teachers** so they can complete the chart. Emphasize that these effects can vary a great deal from person to person.

Discuss both the positive and negative implications for young people of the effects outlined on the chart. For example, it's good for a shy person to be able to relax and be more talkative. But it's not good if he or she is able to do this *only* after having one or two drinks. Also, an athlete who wants to celebrate a victory with team mates should be aware that muscle tone is impaired for up to 48 hours after drinking, so that you're more vulnerable to injury in practices the following day.

Step 4
The effect of alcohol can vary a good deal from person to person depending on many factors. Test your alcohol knowledge and mark true or false beside each of the following statements.

- ☐ If a person is drinking in a highly emotional situation, the effect of the alcohol may be increased.
- ☐ If a person drinks three-quarters of a drink in one hour, there will be little noticeable effect.
- ☐ Having food in your stomach will, at first, slow down the absorption of alcohol into the bloodstream so you will not feel the effects as soon.
- ☐ The larger the person, the more blood he/she has and the more the alcohol is diluted when it reaches the brain; thus a larger person will not feel as much of an effect when drinking the same amount as a smaller person.
- ☐ Having food in your stomach delays the alcohol's effect, but doesn't prevent it.
- ☐ Women tend to have more fat tissue and less water per kilogram than men; thus they have not as much fluid in which to dilute the alcohol and it has a greater effect on them.
- ☐ A man who has had a lot to drink may have difficulty having an erection.
- ☐ People who have had drinking experience over several years generally learn what effect certain amounts and types of alcohol have on them.
- ☐ Alcohol seems to have a greater effect on women during the premenstrual period and may make them feel sick more easily.
- ☐ A more experienced drinker is usually able to compensate for alcohol's effect, and appear not as affected as an inexperienced or younger drinker.

See page S3 for answers.

Step 5
Ask: **What's a good rule to follow to keep alcohol from interfering with what you do and how you feel?**

Have no more than three-quarters of a drink an hour, since it takes that time, on average, for your liver to burn off (metabolize) the alcohol in 5 oz of wine, 12 oz of regular beer, or 1½ oz of liquor.

Next issue: Why drinking and driving should never be combined.

	Average Effects of Alcohol with:		
	1 drink	2-3 drinks	5-6 drinks
Physical	• heart action speeds up • skin flushes	• body systems slow down • physical coordination becomes impaired • speech becomes slower	• heart and breathing rate slow down • blurred vision • fuzzy speech • impaired hearing • poor physical coordination, may stagger or trip • reactions are much slower • may feel nauseated
Behavioral	• inhibitions become lowered • may become more talkative	• may talk loudly • may do uncharacteristic or strange things	• movements become clumsy, poorly coordinated • may do uncharacteristic or strange things
Psychological	• feel good • feel high • may feel more relaxed with opposite sex	• feel sleepy • feel warm, but body temperature is actually going down (see Dear Karen next month for more on this)	• feel strange • may feel "out of it" • may find it hard to communicate with others • may feel sick, depressed, guilty

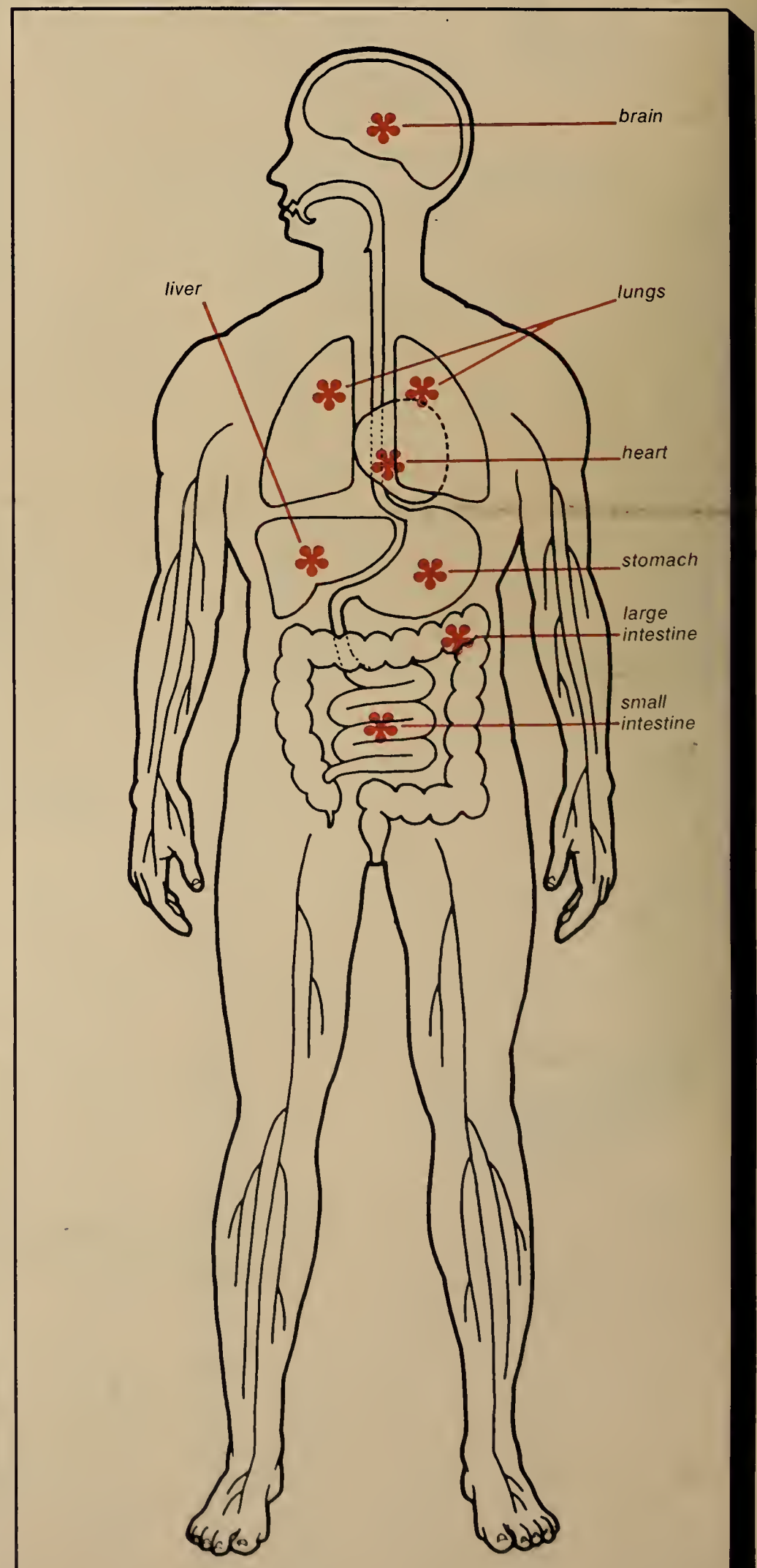


Figure 1 These major body organs are affected by alcohol.

Credit for figure 1: Bundeszentrale für gesundheitliche Aufklärung, Köln, Ernst Klett, Stuttgart, 1980

1982

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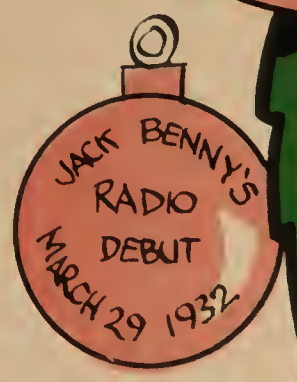
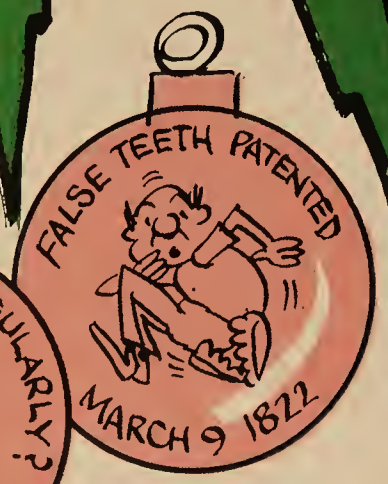




The Journal

DON'T LEAVE HOME WITHOUT IT!

Hardley Jones

Easterner? Westerner?

Any of us who have left our dog-chewed slippers at hearthside and drifted across Canada, have heard that question. Either pleasantly curious or as aggressive as a loaded pistol poked up the left nostril.

The question has often been asked of Yardley Jones, whose cartoons have appealed and appalled from coast to coast — graphically addressing Canadians from such varied rostrums as **The Journal** of the Addiction Research Foundation, The Edmonton Sun, The Montreal Star, The Toronto Telegram, The Edmonton Journal and The Canadian Churchman.

He's often wondered himself, Easterner? Westerner? — For one in whose boyhood ears still sighs the seaport sounds of Liverpool and the crash of wind-torn waves on Wales' craggy shores. How West can you get, or perhaps, how East?

Though no Vasco da Gama he, nor David Thompson, he's made a major discovery. A free-flowing link twixt Newfies and Nanaimoans, Cap de la Madelaineans and Moose-Jawees. Humor.

Even though the Federals, forever fostering separatism, tear asunder the time-honored ties of a national railroad, and bedevil bi-culturism, they can never quell, indeed, they inadvertently feed the unifying roar in which the twain do meet. Laughter.

Be it with a wry smile or an enraged guffaw, a bone-shaking belly laugh, or a rueful grin, Canadians become united.

While lobbying with the Prime Minister, the Queen, and her court jester to include in the Constitution a National Laughter Day, Yardley Jones recently launched a National cartoon book, **Yardley Jones Cartoons,*** for our united amusement.

(*Available from Canadawide Features Ltd, 333 King St East, Toronto, and from most Coles, Classic, and W.H. Smith book stores across Canada.)

NEWS

Large-scale international study gets underway

UN probes drugs/crime link

By Pat Ohlendorf

TORONTO — The first large-scale attempt to compare addiction, criminal behavior, and penal systems in different countries is now getting under way.

Run by the United Nations Social Defence Research Institute (UNSDRI), it is also the first such study in which individual countries will participate fully, Tolani Asuni, director of UNSDRI, told **The Journal**.

Researchers hope that will make for more useful recommendations, he said.

"We want to study in some depth the relationship between drug addiction and crime. Not selling drugs — but rather the type of criminal behavior that may stem from being an addict."

As well as the continual need for cash that motivates certain crimes among addicts, "some drugs, like amphetamines, may lead to paranoid delusions which would make the patient react in an aggressive, criminal way," he said.

"We're also looking at the legal systems in various countries regarding the control of drugs, and the relationship between harsh legal systems and addiction, and lenient legal systems and addiction. In some countries the sanction is more treatment-oriented than in others."

The project includes about 12 countries, representing a mix of geographical locations, drug problems, legislation, and penal systems. So far, Britain, Sweden, Portugal, Italy, Costa Rica, Brazil, Argentina, Malaysia, Singapore, Nigeria, and Jordan have joined the study. New York State is also participating and Dr Asuni hopes to secure the participation of another African country and the province of Ontario as well.

In fact, his major purpose in visiting Toronto recently was to interest the Addiction Research Foundation of Ontario (ARF) in the project, but ARF representatives said there was not enough money to finance participation.

"The answer is not positive for the time being, but I'm not taking no for an answer," Dr Asuni told **The Journal**. "I'm trying to see whether some other agency might fund Ontario's participation."

While UNSDRI subsidizes developing countries that participate in research projects, developed countries are expected to come in on their own — which reflects UNSDRI's main purpose.

Based in Rome, it is the research arm of the Crime Prevention and Criminal Justice Branch of the United Nations. Its mandate is to study crime prevention and treatment of offenders, an area that covers problems of social maladjustment, criminality, prison systems, and rehabilitation.

"The focus of our research is on advising criminal justice systems so they can be improved, particularly in developing countries," said Dr Asuni. Drug addiction, therefore, is only one area of interest. A concurrent study focuses on juvenile maladjustment and delinquency in large urban centres in developing countries.

In terms of influencing change, *how* a research study is conducted can be as important as the conclusions it reaches, believes Dr Asuni. In the past, UNSDRI research usually had been carried out by personnel visiting countries and writing up their reports. Such results are not very helpful, said Dr Asuni. "You'll probably be saying things in your report that local officials have been telling themselves for years."

In his two years as director, Dr Asuni has attempted to involve the governments and local researchers in participating countries from the outset.

"The fact that people in the country are participating in the study sensitizes them to the need for research," Dr Asuni said. It also provides government with a broader perspective on their own problems, systems, and laws, he added.

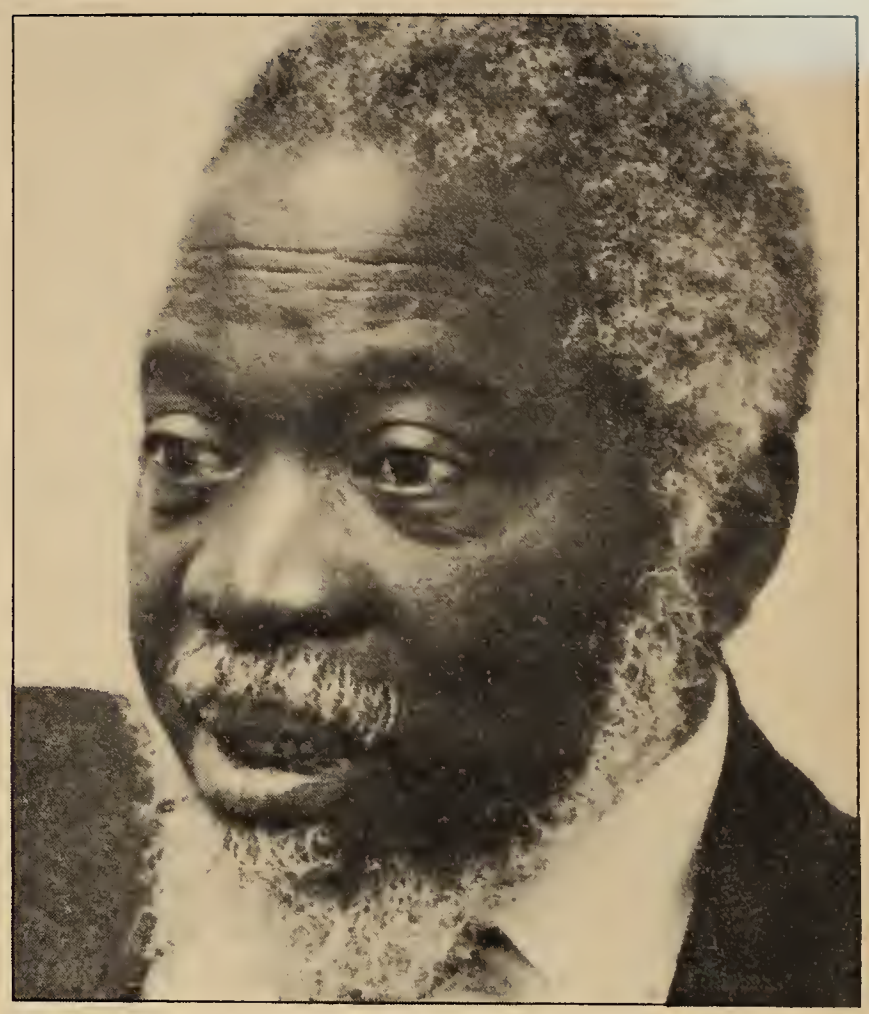
Even with developed countries paying their own way, UNSDRI funds are limited. Money to operate and to provide grants for developing countries comes out of the Social Defence Trust Fund, a UN collection box to which member states are requested to contribute. The money is running out because few countries oblige.

Individual crimes are the focus in the current study. "By and large, larceny is larceny, though it may be labelled differently in different countries."

Funded for one year, the study will probably take longer, Dr Asuni believes. "It's an ambitious and difficult project because the problems are not the same in various countries," he said.

What sorts of recommendations or conclusions might come out at the end? "If it's found, for instance, that very harsh forms of punishment do not seem to control addiction or crime rates, then we would share this information.

"We are also looking into informal controls like education, family set-ups, recreational facilities, and membership in socially acceptable organizations. If these informal controls turn out to be correlated with lower levels of addiction and crime, then this would form another recommendation."



Asuni: 'Our focus is on guiding criminal justice systems.'

Asked whether it isn't intuitively obvious that people addicted to drugs commit more crimes, proportionally, than those not addicted, Dr Asuni replied: "Do they commit crimes because they're addicts, or because the same thing that made them addicts makes them commit a crime?"

When he finishes his term with UNSDRI, Dr Asuni intends to return to Nigeria and clinical psychiatry. "Caring for patients is my real work. The inspiration to do the academic and the international work came from seeing patients."

Drug abuse by migraine sufferers doubles number of headaches — study

By Jean McCann

KYOTO, JAPAN — Drug abuse by migraine patients trying to combat acute attacks backfires, a Swiss researcher told the International Migraine Symposium here.

The abusers get paid back for their abuse by having twice as many headache days as people with migraine who don't abuse their medications.

"It's like getting a short loan with immense interest," Hansruedi Isler of the University of Zurich said, "because afterwards you have to pay for this. And these patients seem to pay for their instant migraine relief with a large amount of chronic headache days, and sometimes a large amount of migraine attacks."

By "abuse," Dr Isler said he was referring to those patients who take 30 or more tablets a month of ergotamines, dihydroergotamines, analgesic compounds, or diazepam or diazepam-like drugs, either singly or in various combinations.

He found that in 104 patients who took 30 or more tablets a month, there was a headache incidence of an average of 24.9 days, close to daily headaches. In contrast, patients who took 29 or fewer tablets a month, 131 of them, suffered from headache only 12.2 days a month.

He said the drug abusers appear to overdose because they are anxious, and ever-fearful of the next attack. And physicians don't help because they commonly advise patients to be sure to take the medications immediately, which is especially necessary for the ergot-type drugs to work.

The problem with these drug-dependent patients, however, may be that they misinterpret the signals of an oncoming attack, or have a lower threshold for whatever triggers their migraine attacks.

Dr Isler said that at times the abusers had to be treated as inpatients with the use of dexamethasone for withdrawal.

Of 87 patients successfully treated, four were able to forego all medication. The rest were given beta blockers, antidepressants, or antiserotonin agents, alone or in combination, as migraine prophylaxis.

"The simplest measure I can recommend is the rule not to take immediately-effective drugs against migraine attacks on more than four days within one month, regardless of dosage. This should, I feel, be printed on every package of these products."

Dr Isler also found that whenever the patients were given analgesics for other reasons, such as dental work, they began an abusing pattern again, even if they had previously quit. This, in turn, resulted in an immediate worsening of their headache frequency.

To stop the drug dependence pattern, he said, inpatient care is required for some patients. Also, doctors must be vigilant as 51 of 87 patients successfully withdrawn from drugs relapsed later.

New call for cig warnings

WASHINGTON — Two United States senators want legislation aimed at educating tobacco smokers about the dangers of cigarettes. They aim to expand federal anti-smoking programs and require five different health warnings to be placed on cigarette packets and advertisements in rotation.

NGOs must cooperate

MALAYSIA — The need for regional cooperation between volunteer agencies in the field of drug abuse is particularly vital in South East Asia, says Eva Tongue, deputy director or the International Council on Alcohol and Addictions.

In an address to the Third Meeting of Non-Governmental Organizations in Drug Abuse Control, Dr Tongue stressed the need for a coordinated effort, not only between various volunteer organizations, but with the national governments as well.

"This is especially important in the South East Asia region because of commonalities in the culture, the types of drugs available, and, to some extent, the control measures applied in the region."

Drinkers' sleep disturbed, not helped, by nightcap

DETROIT — The drinker's "nightcap" is a misnomer, suggests a recent study.

Far from ensuring an uneventful night's sleep, a drink before turning in might do just the opposite.

Drinking results in lower levels of oxygen in the blood, and periods when breathing is arrested for 10 seconds or more. The latter condition, called sleep apnea, may be harmless in healthy people, but could prove fatal for those with serious pulmonary or cardiovascular conditions.

These were two warnings voiced by Vincente C. Taasan in a report to the 76th Annual Meeting of the American Thoracic Society here.

With chief investigator, A. Jay Block, and Philip G. Boysen and James W. Wynne of the University of Florida College of Medicine and the VA Medical Center in Gainesville, he monitored breathing patterns, measured the amount of oxygen in the blood, and recorded electrical activity in the brains of 20 healthy men after they had drunk vodka and fallen asleep.

In the two-night study, 11 men drank plain orange juice the first night, and the second night orange juice spiked with 100 proof vodka, two ml per kilogram of body weight. The other nine men had spiked drinks the first night and plain orange juice the next.

After drinking alcohol there was a significantly greater number of episodes of disordered breathing during sleep. The men stopped breathing for 10 seconds or more, a total of 110 times. On the night they had only orange juice, they had only 20 episodes of disordered breathing.

Almost all of the 20 men were affected similarly after drinking: 18 men had at least one occurrence of disturbed breathing after the vodka nightcap.

With placebo, only nine had disordered breathing. After the vodka nightcap there were almost twice as many breathing abnormalities, or 383 compared with only 207 after the orange juice, a statistically significant difference, Dr Taasan said.

The most common abnormality was a drop in the oxygen content of the blood. In addition, the number of abnormal respiratory events and the number of times the men stopped breathing per hour of sleep were also significantly greater after drinking.

The researchers also found that these changes persisted during the second night, even though no alcohol was consumed. But they are unsure what this finding means.

NEWS

EAPs have highest alcoholism recovery rates

By Alan Massam

LONDON — The highest recovery rates for alcoholism are found in office and factory rather than clinic or hospital programs.

This may be for two reasons: 1) attempts to detect and treat alcoholism are most successful in its middle stage and, 2) job, status, and income may mean more to many alcoholics than has been realized previously.

For according to the United States National Council on Alcoholism (NCA), the average alcoholic will give up his or her family five years before she or he loses a job.

These compelling points in favor of employee counselling were made at the World Conference on Alcoholism here by Dale A. Masi.

Dr Masi, director of employee and counselling services to the US department of health and human services, told the conference that rather than training supervisors to look for symptoms of alcoholism, employee counselling focuses primarily on workers' job performance and attendance.

Although not all people with job performance problems suffer from alcoholism, the National Institute of Alcoholic Abuse and Alcoholism estimated 50% do.

Moreover, the National Council on Alcoholism believes approximately one in every 10 to 13 employees has alcohol problems. This is estimated to cost the US economy from $8 billion to $15 billion annually with two thirds of this loss attributable to absenteeism.

Dr Masi said because it is a progressive disease, alcoholism often takes from 10 to 15 years to reach its middle stages. So the valued worker is often occupying a position of responsibility when the alcoholism is taking effect. "Therefore, treatment of these employees becomes a matter of importance to a company," Dr Masi said.

Stanford Research Institute calculated from a study of alcoholism in industry that by treating workers with a drinking problem, industry saves about $6000 per alcoholic employee per year.

The speaker stressed the primary mechanism in alcoholism is denial. The alcoholic will not voluntarily seek help and will continue to deny and cover up the problem. Therefore confrontation is necessary to precipitate a crisis which, in turn, may motivate the individual to do something about his drinking.

"Rather than having to hit bottom, as Alcoholics Anonymous states, confrontation with a supervisor at work can provide a chance for the worker to obtain treatment before losing his or her job," Dr Masi said.

Masi: confrontation necessary.

The relationship between the employer and employee provides a legitimate reason for confrontation and intervention when deteriorating job performance is documented. If an employee is not performing to capacity, the employer has a right to take action.

Dr Masi went on to quote Paul Roman as "well known in the field as an evaluator." She said he had described the following assumptions for implementing employee counselling:

- Poor job performance is the best indicator of a likely underlying drink problem;
- Alcoholism can be regarded as a medical problem of the workplace and should be treated as such;
- Employees should not be disciplined for poor performance while seeking assistance for a drink problem;
- Return to adequate job performance should be regarded as the criterion for judging treatment a success.

Staff 'protect' executive drinkers

LONDON — The typical stressed executive who turns to alcohol for relief often needs to keep his drinking a closely-guarded secret, the World Conference on Alcoholism here was told.

W. Linford Rees, consulting physician to St Bartholomew's Hospital, told delegates this is particularly the case when the executive has a very high position and is able to delegate responsibility.

Sometimes, the alcoholic executive's deviant drinking, particularly if he is at the highest management level, is supported and protected by a group of lower executives.

But this "protective clique" may in turn gain power and material gain by using a mild or severe form of blackmail in the form of clearly understood although unexpressed threats of exposure.

The top executive, the professor said, gives into such demands rather than risk exposure. Experience shows the greatest risk controlled heavy drinkers have of developing physical alcohol dependence occurs when they enter situations where there are few restraints on heavy drinking.

Executive posts which carry severe pressures, ambiguities, uncertainties, and anxieties are potentially stressful and alcohol and drug use may serve as a readily available means of coping with such stress.

It is often assumed such stresses are temporary, and will settle down, and that no one will endure emotional or physical pain for long. But this is not always borne out in reality.

Professor Linford Rees said all executives require fairly comprehensive medical, nutritional, exercise, and stress evaluation before entering what he described as stress management programs.

Treatment should include health education with specific objectives to reduce cholesterol, eliminate cigarette smoking, and reduce blood pressure and weight.

Learning to manage stress would be achieved by lectures, small group discussions, control of hostility, physical activity, good nutrition, and training in interpersonal skills.

AMA slams harmless pot impression

CHICAGO — The American Medical Association has stiffened its attitude towards marijuana use, despite the fact doctors have been investigating the drug's potential therapeutic effects.

In a recent statement, the AMA cited new evidence marijuana is hazardous to health and called on legislators to send young people a clear message that its use can be harmful.

The AMA contends legislators may have created the impression marijuana is not harmful. Such a misconception was created by legislative actions over the past few years that reduced legal penalties for possession and made marijuana available for certain medical uses, the AMA said.

But a new report from the AMA's council on scientific affairs concludes that although marijuana may have bona fide medical uses, that does not mean the drug is harmless and safe for recreational use.

The council said law-makers have been correct in trying to substitute fines for jail sentences for persons convicted of possessing small quantities of marijuana for personal use.

But such fines must be substantial enough to deter people considering use of marijuana.

The AMA flatly states "marijuana is dangerous" and proposes "stringent penalties and vigorous prosecution" for the sale and other trafficking in marijuana.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Susan Reid, coordinator of the group, at (416) 595-6150.

Chicken

Number: 478
Subject heading: Smoking
Details: 5 min; 16mm; color.
Synopsis: In this slide presentation on film, Billy and Sally contemplate how they should spend a free afternoon, and finally decide to go to the park to play with some friends. A boy on a bicycle offers them a cigarette. Billy flatly refuses, but Sally and another boy feel intimidated by the boy's suggestion that they are frightened and decide to take a puff. Sally doesn't like the taste and offers Billy an apple suggesting to him that "it tastes much better." The boy with the cigarette rides off in a cloud of smoke calling back to the group, "chicken."
General evaluation: Fair. It was poorly produced, unrealistic, and boring.
Recommended use: Likely to benefit children aged eight to 11 years.

Wise Use Of Drugs: A Program For Older Americans

Number: 450.
Subject heading: Senior citizens; Drug use: etiology and epidemiology; attitudes and values.
Details: 32 min; 16mm; color.
Synopsis: The findings and recommendations of a study group on the use of drugs by the elderly are reported in this documentary film. Each part of this 3 part film deals with a major area of concern: how to communicate with doctors effectively; buying drugs "wisely" (reducing costs and obtaining relevant information from pharmacists); and, healthy aging. The importance of taking drugs carefully is stressed and alternatives to drug use are suggested. Through interviews with professionals and drug users, some of the problems and frustrations experienced by the elderly in each of these areas are discussed and suggestions on how to overcome them are made.

Voices

Number: 488
Subject heading: Skid row; archival.
Details: 15 min; 16mm; black and white.
Synopsis: A thirty-year old man is followed through several months of his life as an alcoholic. He relates his experiences as an alcoholic and how alcohol has ruined his life. His account is supplemented by voice-over comments made by other alcoholics. Flashbacks of the past are interjected using such scenes as a mission, panhandling, a police "cooler," and a rehabilitation centre. The film finally ends with the death of this man.
General evaluation: Very Poor — Poor. The group felt that this film was depressing and did not like the outdated and unrealistic portrayal of skid row. Despite the appropriateness of this film's length it was judged to be an ineffective teaching aid due to the uncertainty of its message and its exaggerated melodramatic presentation.
Recommended use: This archival film is not recommended for any audience.

The Mountain

Number: 489
Subject heading: Attitudes; Trigger Films.
Details: 12 min; 16mm/videocassette; color.
Synopsis: This animated film narrated by Dick Van Dyke is about a small town with a big problem — a mountain. Most people who climbed the mountain enjoyed it, but "some had trouble." After a series of accidents and injuries on the mountain the town decides to implement a number of preventive programs (eg build a fence around it; mountain education in school; establish mountain first-aid stations). Despite their efforts, people continued to climb the mountain. Finally, they decide they "can't move it and it won't go away" so they "need to work on ways to deal with it safely and accept it for what it is." With this decision the town starts a community bulletin board which lets people know what other activities are going on in the town, and starts teaching mountain climbing skills to those who want to climb the mountain.
General evaluation: Good — Very Good. This film was judged to be an excellent teaching aid and especially appropriate for community development. It was rated as a well-produced, interesting, and informative film which would be helpful in decision-making processes.
Recommended use: Beneficial to adults and community workers. The presence of a resource person would facilitate discussion of the concepts presented.

Narcotics File: The Victims

Number: 484
Subject heading: Drug use: etiology and epidemiology; treatment/rehabilitation; history, drugs and youth.
Details: 27 mins; 16mm; color.
Synopsis: This documentary explores the various option available for dealing with the problem of heroin addiction, including treatment with the use of methadone, therapy in group encounters held in "drug-free communes," and jail sentences. An international perspective of this social problem is illustrated with examples of different treatment and rehabilitation methods. The social implications of heroin addiction are touched on, leaving the viewer to question his/her opinion of "whether or not to hire a former addict." The film presents a number of issues, concluding with the suggestion "abstinence still remains as the only answer to something that still has no cure."
General evaluation: Fair. Although the film was judged to be informative, the poor production techniques (using incongruent audio and visual tracks) left the viewer confused as to the message
Recommended use: The film would be beneficial to drug users, health professionals, and adult audiences at the senior level (age 15-18 years) in classes such as sociology.

DEPARTMENT

New Books

by RON HALL

Narcotic Antagonists: Naltrexone Pharmacochemistry and Sustained-Release Preparations

. . . edited by Robert E. Willetee and Gene Barnett

This NIDA Research Monograph, No. 28, summarizes some of the approaches pursued over the past several years. General overviews of the background for chemical and pharmacological decisions are given; and, in addition, details of the analytical methods for measuring naltrexone levels, the pharmacokinetics of naltrexone in test animals and man, and the development and manufacture of clinical materials are presented.

(US Government Printing Office, Washington, DC 20402, 1981. 236 p. $8.00 GPO S/N 017-024-00981-4)

Demographic Trends and Drug Abuse, 1980-1995

. . . edited by Louise G. Richards

The study reported was undertaken to project drug abuse for young adults in future years by examining age trend data in conjunction with data on the non-medical use of drugs. The opening chapter outlines the purposes of the study and reviews the methodology employed for making projections of the number of young adult drug abusers. The second chapter reviews the changing structure of the population. Several drug abuse data sets are reviewed in chapter three, which specifies the data to be used as the basis for projecting future drug abuse. The fourth chapter presents projections of the number of young adult drug abusers in 1985, 1990, and 1995. The project trends in non-medical drug use by young adults are summarized in the final chapter and recommendations are made for additional research.

(US Government Printing Office, Washington, DC 20402, 1981. 112 p. $4.00 GPO S/N 017-024-01087-1)

Psychotropic Substances and Their International Control

. . . edited by Reginald G. Smart, Glenn F. Murray, and H. David Archibald

This book includes the background papers prepared for a meeting convened in September 1980 to examine the issues surrounding the development of the treaty (Convention on Psychotropic Substances, 1971); the problems and benefits of the treaty; and how the problems may be solved. Also included is the report of the meeting. The history and rationale for the Convention; reflections on its development, content, and acceptance; as well as questions and issues concerning the Convention, are presented. Papers are provided for Canada, Egypt, Federal Republic of Germany, Hungary, Malaysia, Republic of Mexico, Nigeria, Sweden, the United Kingdom, and the United States. The Working Group identified a variety of benefits accruing from the Convention as well as a number of problems with its rationale and content which would lead to low rates of ratification or problems in implementing the Convention. The Working Group proposed a number of recommendations intended to improve the control of drug abuse on an international level and the acceptance of the Convention on Psychotropic Substances.

(Addiction Research Foundation, Marketing Services, 33 Russell Street, Toronto, Ontario, M5S 2S1, 1981. 230 p, $22.95, ISBN: 0-88868-053-8)

Alcohol: Public Education and Social Policy

. . . by the Addiction Research Foundation Task Force on Public Education and Social Policy

This report presents a brief historical overview of alcohol problems, economics, conceptualizations, and solutions in Ontario; a review of the effectiveness of education/information approaches; and a review of the impact of regulatory/control policies regarding alcohol. The Task Force concludes that the evidence regarding the impact of alcohol advertising is conflicting, and that, despite the apparently unpromising mass-media approach to public persuasion, it recognized the pervasive nature of mass-media and noted its extensive use. The Task Force also concludes that successful public persuasion, either through mass-media or policy intervention, requires both an understanding of the impact of alcohol regulatory/control policies and an awareness of how such policies are made. It further concludes that expectations of major attitudinal shifts through large-scale media education or advertising campaigns are not confirmed by the research evidence, but the mass-media might be used to crystallize and develop existing support for control policies given adequate planning and resources. Fourteen recommendations are made.

(Addiction Research Foundation, Marketing Services, 33 Russell Street, Toronto, Ontario M5S 2S1, 1981. 234 p, $14.95, ISBN: 0-88868-054-6)

Other Books

Dimensions of Family Therapy — Andolfi, Maurizi and Zwerling, Israel (eds), Guilford Press, New York, 1980. Family therapy and community psychiatry; society, drug abuse and the family; therapy; training. 280p. $20.00.

Drinking Behavior Among Southwestern Indians: An Anthropological Perspective — Waddell, J. O. and Everett, M. W. (jt eds), University of Arizona, Tucson, 1980. History; patterns; contemporary assessments by Native American observers and public health workers; some comparative conclusions. References. 248p. $20.00.

Drinking, Homicide and Rebellion in Colonial Mexican Villages — Taylor, William B., Stanford University Press, Stanford, 1979. Colonial setting; drinking. Bibliography, index. 242p. $16.50.

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ISSN 0044-6203 Printed in Canada

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Annual Meeting of the Ontario Psychiatric Association — Jan 28-30, Toronto, Ontario. Information: Frank E Cashman, Clarke Institute of Psychiatry, 250 College St, Toronto, Ont M5T 1R8.

Annual Convention of the Ontario Psychological Association — Feb 11-13, Ottawa, Ontario. Information: Dr Carl Rubino, Dr Pierre Ritchie, Ontario Psychological Association, 1407 Yonge St, Ste 402, Toronto, Ont M4T 1Y7.

Detox Training Programs (Non-Medical) — Feb 22-26, Apr 19-23, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont M5S 2S1.

Mental Health Information Systems: Problems and Prospects — May 14-15, Toronto, Ontario. Information: Hincks Lectures, Ontario Mental Health Foundation, Ste 1708, 365 Bloor St East, Toronto, Ont M4W 3L4.

73rd Annual Conference Canadian Public Health Association — June 21-24, Yellowknife, Northwest Territories. Information: Gerald H. Dafoe, Executive Director, Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, Ont K1Z 8N8.

Fifth World Conference on Smoking and Health — July 10-15, 1983, Winnipeg, Manitoba. Information: Fifth World Conference on Smoking and Health, PO Box 228, Station B, Ottawa Ont K1P 6C4.

United States

Family Program For Professionals — Offered once each month, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Alcohol/Drug Counselling skills — Jan 11-15, Apr 19-23, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

An Integrated Management System for Administrators in Alcoholism — Jan 20-21, Boston, Massachusetts. Information: Kim Hilberg, Program Coordinator, NAATP, 17861 Cartwright Rd, Irvine, CA 92714.

Alcoholism — The Search for the Sources — Jan 20-22, Winston-Salem, North Carolina. Information: Elaine Woody, Center for Alcohol Studies, School of Medicine, The University of North Carolina at Chapel Hill, 335 Medical School Building 207H, Chapel Hill, NC 27514.

Outpatient Treatment for Alcohol/Drug Dependent Persons — Jan 25-27, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Bioavailability of Drugs and Clinical Pharmacokinetics — Jan 25-27, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816.

Alcohol/Drug Dependency and Mental Illness — Jan 28-29, Mar 15-16, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Nursing Series — Pharmacology, Detoxification and Withdrawal: Basic Skills, Counselling Skills for the Nurse — Feb 1-5, May 17-21, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Parish Ministry and Alcoholism: A Pastoral Response to a Family Problem — Feb 10-12, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Alcohol/Drug Series — Mar 3-5, Apr 28-30, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Advances in Alcoholism — Mar 5-6, Newport Beach, California. Information: Kim Hilberg, Raleigh Hills Foundation, 17861 Cartwright Rd, Irvine, CA 92714.

Issues of Sexuality in Alcoholism/Drug Abuse Counselling — Mar 11-13, June 3-4, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Pharmacology for the Alcohol/Drug Counsellor — Mar 22-23, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Group Skills — Mar 24-26, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

American Orthopsychiatric Association 59th Annual Meeting — Mar 29-Apr 2, San Francisco, California. Information: The American Orthopsychiatric Association, Inc, 1775 Broadway, New York, NY 10019.

Third Regional Conference on Substance Abuse — Mar 31-Apr 1, Cincinnati, Ohio. Information: Ann Blankenhorn, Central Community Health Board, 532 Maxwell Ave, Cincinnati, OH 45219.

Employee Assistance Programs — Apr 14-15, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Assessment and Diagnosis For Chemical Dependency — Apr 16, June 8, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Abroad

12th International Institute on the Prevention and Treatment of Drug Dependence — Mar 22-26, Bangkok, Thailand. Information: International Council on Alcohol and Addictions, Case postale 140, Ch-1001, Lausanne, Switzerland.

ALC 82, International Conference on Alcoholism — Mar 30-Apr 4, Oxford, England. Information: Dr Philip Golding, Broadway Lodge, Oldmixon Road, Weston-super-Mare, BS24 9NN, Avon, England.

First Nordic Congress on Traffic Medicine — June 8-11, Linköping, Sweden. Information: Mr Leif Bohlin, Congress Director, Linköping University, S-581 83 Linköping, Sweden.

28th International Institute on the Prevention and Treatment of Alcoholism — July 5-9, Munich, Fed Rep of Germany. Information: International Council on Alcohol and Addictions, Case postale 140, Ch-1001, Lausanne, Switzerland.

11th International Conference on Health Education — Aug 15-20, Hobart, Tasmania, Australia. Information: Joy Faldt, Australian Society of Health Educators, PO Box 818, Fortitude Valley, Queensland, Australia 4006.

Fourth World Congress for the Prevention of Alcohol Problems, Alcoholism, and Drug Dependency — Aug 29-Sept 2, Nairobi, Kenya. Infomation: ICPA — International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St NW, Washington, DC 20012.

33rd International Congress on Alcoholism and Drug Dependence — Oct 9-15, Tangier, Morocco. Information: Archer Tongue, International Council on Alcohol and Addictions, Case postale 140, Ch-1001, Lausanne, Switzerland.

Endorphins: ifs, buts, maybes

By Pat Ohlendorf

TORONTO — Unlocking the secrets of endorphins — the brain's own opiates — may (someday) revolutionize understanding of human behavior, mood, and motivation and yield better ways of treating pain, drug addiction, mental illness, and other problems.

In the meantime, there are more ifs and maybes than knowns.

Results obtained in one lab often cannot be duplicated in another. Scientists disagree on the methods used in experiments, the results, and the interpretations of the results. And speculations abound.

Too, with laboratories around the world investigating endorphins, simultaneous publications on the same topics commonplace, the high costs of the research, and only so much grant money to go around, competition is stiff.

Endorphin research is exciting, fast-paced, and very untidy.

What are some of the "knowns"? So far half a dozen endorphins have been identified: leu-enkephalin, met-enkephalin, alpha-endorphin, beta-endorphin, gamma-endorphin, and dynorphin. All are peptides. All contain the basic enkephalin chain. (Enkephalin is the shortest with only five amino acids.) All have been found in the brain, the spinal fluid, or nerve tissue.

Some have been found in the pituitary gland, the adrenal gland, sexual organs, the intestines, amniotic fluid, even in mother's milk. Some appear to block pain, induce euphoria, control digestion, blood pressure, body movements, and hormone secretions.

Pain, stress, acupuncture, electrical stimulation, and jogging all increase the release of endorphins from various tissue cells (well, beta-endorphin at any rate). Possibly meditation, sex, and alcohol do the same.

But even this nutshell of knowns has cracks around the edges. The most obvious is the terminology: scientists haven't quite decided what to call the things. Some simply call all six "endorphins," others prefer "endogenous opiates," "enkephalin-like compounds," "opioid peptides," or just "opioids." Part of the confusion arises from having only a very thin handle on their functions. When endorphins are in the brain and nerve tissue, for instance, they act like neurotransmitters. In the blood, they probably act like hormones.

Then too, the list may not be complete. There are probably more endorphins waiting to be discovered.

Bruce Pomeranz of the University of Toronto: "At a recent scientific meeting it was suggested we stop naming them because we don't know what their functions are and which ones are most important."

There's even disagreement about whether all six are the genuine articles. Avram Goldstein of Stanford University's Addiction Research Foundation told **The Journal**: "The role of the enkephalins is completely up in the air now, in light of the discovery of large, pro-enkephalin precursor proteins. It may be that the active peptides are long ones, not as short as enkephalins. That's just a thought. There's no evidence for or against it."

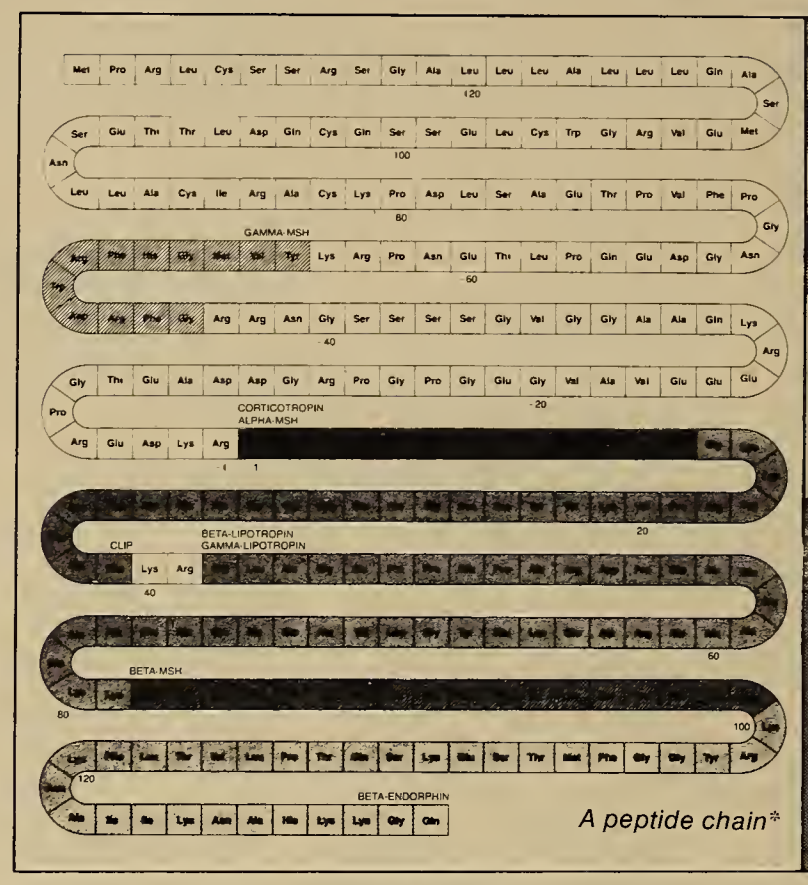
What Dr Goldstein says about dynorphin, which he discovered in 1979, may hold true for all the endorphins with only slight exaggeration: "Dynorphin is obviously enormously potent and enormously important, but we don't have any idea what it does."

But most of the researchers agree that when it all shakes down — perhaps in five or 10 years — there should be, among other things, new treatments for drug addiction, mental illness, and pain.

In fact, if no therapeutic good for addicts comes out of the research, it will seem like a betrayal, for the burgeoning new field grew out of biochemical studies of morphine and heroin addiction. The word "endorphin" itself is a contraction of "endogenous morphine."

All current research traces back to the surprising discovery in 1971 (by at least three laboratories, simultaneously) that embedded in the membranes of certain brain cells are receptors which fit the morphine molecule.

The natural question that arose — "Why has the body evolved cell receptors specifically designed to receive a molecule from the poppy seed?" — started the race to discover the body's own opiate, a substance so similar to morphine that the cell receptors mistook the plant product for the real thing.



*A peptide chain**

In 1975, at least two labs, again simultaneously, discovered the enkephalins.

Today, seven years later, there is still only one substance known to *decrease* the body's production of endorphins: opium and its derivatives, such as morphine and heroin.

Harold Kalant of the Addiction Research Foundation of Ontario (ARF) explains why: "Because morphine and endorphins are so similar in structure and hook into the same receptors, a high level of morphine in the blood signals to the body to diminish or shut down the production of the endogenous material because there's already enough (morphine) doing the job. It's a negative feedback mechanism."

Even though it's still not understood exactly how people become addicted to opium derivatives, endorphins are believed by many researchers to hold the key. Perhaps the body's ability to synthesize endorphins atrophies as morphine or heroin takes over. Perhaps dependency is somehow built into the morphine molecule.

Or perhaps, suggests Dr Kalant, endorphins may act as transmitters in the brain's pathways connected with reward. The satisfaction of hunger, thirst, sex-drive, and possibly drug-producing rewards might partly depend on an action of endorphins. If so, this might offer a way to make the drug experience non-rewarding and therefore unlikely to produce addictions.

Says Dr Kalant: "I think if one finds out what controls the synthesis and release of endorphins, it may be possible to develop a drug which stimulates the production and release of the body's own material.

"It was quite a few years after the discovery of insulin before people ran across the action of tolbutamide or chlorpropamide which caused increased release of the pancreas' own insulin."

A drug that increases endorphin synthesis could well turn out to be a non-addictive painkiller or a cure for heroin addiction. Unfortunately, simply injecting endorphins — either extracts or synthetics — won't do the job. Because of negative feedback, we get just as addicted to the endorphins if taken in pill or shot form as we do to morphine.

But there are now emerging hints that one drug does appear to increase endorphin production: alcohol. Three months ago, Albert Herz at the Max Planck Institute in Munich found that alcohol raised endorphin levels in animal tissue, and Christina Gianoulakis, working with Dr Kalant and Dr Michel Chrétien, found it increased endorphin biosynthesis.

Dr Kalant: "I emphasize that this is pure speculation, but if the alcohol is acting to stimulate the release of endorphin from some site in the brain or the pituitary, and if the supply of endorphin in the nerve cell from which that endorphin comes is thereby diminished, we are hypothesizing that there will be a short-loop feedback which signals to the same cell that its supply of transmitter, or endorphin, has been depleted so it had better synthesize more."

Thus, while morphine replaces endorphins and the body's production shuts down, alcohol may trigger the release of endorphins, causing production to go up.

But before the work of Drs Herz and Gianoulakis can be considered a breakthrough, the relationship between alcohol and endorphins must be verified by other laboratories. And in any event, because alcohol is also addictive and wreaks havoc in the body in other ways, it is very unlikely that any therapeutic good will come out of this work for heroin addicts (though it may explain why many addicts, when unable to get their drug, turn to alcohol as a substitute). The long-shot hope for the alcohol/endorphin work is that it may illuminate the causes of alcoholism.

Perhaps a more fruitful means of increasing endorphin synthesis, and thus counteracting the addictive effects of heroin and morphine, is acupuncture.

Used for 5000 years in treating pain and a host of other ailments, it is only within the past few years that researchers like Dr Pomeranz in Toronto have shown that acupuncture increases the body's endorphins. "The amount of endorphins in spinal fluid doubles after acupuncture," says Dr Pomeranz. "And as well as feeling relief from pain after treatment, most patients also report euphoria." (Dr Pomeranz, however, suspects that euphoria may be the same thing as "relief from pain.")

One researcher, Dr H.L. Wen in Hong Kong, has used acupuncture to help detoxify addicts in record time. But since all the patients in his study returned to their habit when released from the hospital, Dr Pomeranz suggests a more successful method might be using a portable electrical stimulator in outpatient detox programs, for it does the same thing as acupuncture — increases the body's endorphins.

"If patients could 'zap' themselves whenever they had a craving, the results might be better," says Dr Pomeranz.

Just as the study of heroin addiction led eventually to the discovery of opiate cell receptors, so also, over the past five years, it has opened up another promising possibility: that there may be a causal connection between an upset endorphin system and some mental illnesses.

Workers in several methadone detox programs have noted that when methadone doses were decreased to below 20 milligrams per day, 10% to 15% of the patients developed psychotic symptoms — symptoms which ceased when dosages were brought up to 30 milligrams per day. Some psychiatrists, among them Edward Khantzian of Harvard Medical School, suspect this percentage of the heroin addict population represents mentally ill people who are "self-medicating" with morphine or heroin.

"After sitting with many addicts I began to suspect they craved less for euphoria, but more for relief from the dysphoria associated with anger, rage, and related restlessness that short-term narcotics seem to provide," Dr Khantzian recently told *Science*.

Consensus at an October 1981 conference on brain opiates and mental illness was that at least schizophrenia and depressive illness are somehow linked to endorphins. But whether an increase or a decrease in endogenous opiates is responsible is not yet known. There's evidence for both.

While the jury is out on this question, pharmaceutical companies are already working to come up with endorphin-based drugs to treat specific mental diseases. Robert Frederickson, head of enkephalin research at Eli Lilly in Indianapolis, was "unable to go into detail about what we're doing."

"Some of the efforts going on around the world are questioning whether the endorphins may be involved in the psychoses, or schizophrenia, or depression. So certainly there is interest in anyone developing therapeutic potentials in these areas," he told **The Journal**.

When might such drugs be ready to market? "Even internally it's diffcult to make these kinds of predictions. We don't even know for sure that one will be on the market, but there's potential for that," said Dr Frederickson.

But a larger part of the pharmaceutical companies' endorphin-related research is aimed at the magic pill: an analgesic more powerful than morphine without being addictive. (Endorphins are about 100 times more powerful in killing pain than morphine.)

The fact endorphins are addictive if injected is somewhat daunting, but Dr Frederickson and others in the industry are hopeful: "To have an agent devoid of the dependency liability may not be possible, but I think we can develop analgesics which have *reduced* physical dependence liability compared to the existing agents such as morphine. That could come from better pharmacokinetics, different pharmacokinetics, or different receptor interactions."

Which is yet another new area within endorphin research. While identifying endorphins, figuring out where they're synthesized, what they do, continues at a frenetic pace, a resurgence of research on cell receptors now complicates the picture. It suggests even more promise.

"There are many more classes of opiate receptor than anybody thought of," Dr Goldstein said. "We used to think of one, when they were first discovered. Now there are clearly three, four, maybe five. I suspect we'll eventually find out there's one specific receptor for each type of opioid peptide."

The promise here is that different receptors might promote or inhibit the different effects of endorphins: a little keyhole for pain relief, another for relaxation, another for euphoria, another for dependency, and so on. If so, then perhaps several "magic pills" can be developed, specific agents with no side effects like addiction or mental disorientation. The possibility is, Eli Lilly's caution notwithstanding, that an analgesic *devoid* of side effects just might be found.

While most admit such speculations may turn out to be pie in the sky, they do fire the researchers on.

"Things always get very complicated before they get simple again," comments Dr Goldstein. "The whole area of opioid peptides and their receptors is exceedingly complex today. But I think things will start to get simple again in the next few years."

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*From Neuropeptides, by Floyd E. Bloom

Vol. 11 No. 2 TORONTO February 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

White House to study drunk driving

Small town story stirs US feds

By Michele Kogstad

GAITHERSBURG, MD — A small Montgomery county newspaper that recognized a real problem affecting real lives has sparked creation of a White House Commission on Drunk Driving.

Thanks to the Montgomery County *Courier*, published in Damascus, Md, county Congressman Michael Barnes, and a drunk drivers segment on the television program "60 Minutes" (Jan 10) the program was able to announce to the nation that a commission will be formed.

A formal announcement by the White House was expected as **The Journal** went to press.

Representative Barnes, who has a bill dealing with drunk driving in the House of Representatives, supported by a companion bill in the Senate, became aware of "this neglected national disgrace" some 18 months ago when the *Courier* ran the story of what happened to Cindy Lamb and her infant daughter, Laura.

As Mrs Lamb drove, said the *Courier* story, a previously convicted drunk driver, whose licence was currently revoked and who that day was drunk, crashed into Mrs Lamb's car, paralyzing her daughter from the neck down.

Following the *Courier* report, a nearby Washington TV station WDVM took up Mrs Lamb's story, then *The Washington Post* and *The Washington Star*.

When Representative Barnes became aware of Mrs Lamb's plight, his spokesman Bill Bronrott told **The Journal,** "We thought maybe there was something we could do."

Last fall Representative Barnes submitted a bill to the House which sets up mandatory minimum standards for dealing with drunk drivers. The Barnes bill has an identical companion in the Senate introduced by Senator Claibourne Pell.

It provides a uniform definition of intoxication and specifies a blood alcohol content (BAC) no higher than 100 milligrams per 100 millilitres of blood (0.10%).

Mr Bronrott said Maryland is the only state which defines intoxication at 0.13. It is lower in other states. He added: "We want to make sure that no state has it higher than 0.10 as a legal definition and some states have 0.08, which is just fine."

The bill specifies mandatory loss of freedom for a minimum of 10 days for a first conviction, which can be specified as community service or jail. Repeaters would be jailed. There would be a mandatory loss of licence of up to a year for first offenders and a mandatory minimum of at least a year for repeaters.

There would also be mandatory participation in alcohol rehabilitation or highway safety programs and mandatory fines.

Mr Bronrott said another bill already introduced would upgrade the national driver registry. A computer could be used so that within a state judges would know what is going on in their jurisdictions.

Mr Bronrott said the bill is flexible and allows the states to deal with diverse local circumstances.

After his bill was submitted, on November 13, Representative Barnes, a Democrat, and Representative James Hanson, a Republican, sent a letter signed by 340 other members of Congress, to President Reagan urging a White House Commission on Drunk Drivers be formed.

At about the same time, "60 Minutes" started filming its feature on drunk driving, including interviews with Mrs Lamb, who is one of the leaders of Mothers Against Drunk Driving (MADD) and Montgomery County police officers.

Mr Bronrott said the commission will "finally bring together . . . the wealth of knowledge and resources already out there to map out a national master plan dealing with the problem."

The story of Cindy and Laura Lamb has had its effect in Maryland — the state legislature recently dropped the BAC level from 0.15 to 0.13. Ironically, the veteran state legislator, who in the past had blocked tougher legislation, is from Montgomery County. He has now changed his stance.

During the fall, county Police Captain John Baker set up road blocks in his area to check driver blood alcohol levels, and by the end of the year had netted more than 90 drunk drivers. His idea went over so well that other areas of the county, in a well publicized campaign, did the same thing on New Year's eve.

Mr Bronrott said that, at the moment at least, the National Highway Traffic Safety Administration is opposed to the Barnes legislation. "They say it infringes on states' rights. They feel the problem is a state and local problem, and that the federal government should just be assisting the states.

"We feel we are outlining a comprehensive alcohol traffic safety program and providing a skeletal structure from which the states can operate."

CRASH — Drunk drivers are responsible for more than 50% of deaths on highways in North America. Many Western European countries have for years had stringent drinking and driving laws, with mandatory fines and licence revocation that would make many North American legislators blanche for fear of political ramifications. The seriousness of the problem, however, is being increasingly recognized, as these reports show.

Ontario hands police more power

By Pat Ohlendorf

TORONTO — The Ontario government has cracked down on drinking and driving, amid outcries from sections of the public and the media that civil liberties are being violated.

Bill 178, a new Ontario law, enables police to conduct random roadside spotchecks and to screen drivers for alcohol consumption. If a blood alcohol concentration of 0.05 to 0.08% is indicated, police can suspend the driver's licence for 12 hours.

"Unfortunately, there's no way to insure randomness of the spot checks, because police have the power to harass people now if they want to," Ontario Attorney General Roy McMurty told **The Journal**.

"All we can do is to police the police. We've asked the Ontario Police Commission to monitor this very carefully.

"We want to hear from the public about any allegations that the new law is being used to harass people or is being applied in a discriminatory fashion."

The controversial Bill 178 became law as 1981 drew to a close. And Ontario joined four other provinces in having a standard of safety on the highways that in effect is more stringent than the federal Criminal Code.

Preliminary statistics from police suggest the new law is working. There were fewer accidents and drunk driving offences during the 1981 holiday season than in 1980 — which Mr McMurtry, who is responsible for the new legislation, finds "encouraging."

But to many editorial writers in the province, the stronger police powers contained in Bill 178 meant infringements of individual rights. Police officers were being given carte blanche to act as "cop, judge, and jury" and to punish citizens without a trial, some charged.

"It's never an easy task to weigh the rights of the individual against public rights generally," Mr McMurtry told **The Journal.**

"But we decided it was time to consider the rights of all the users of the highways, not just those who want to drink and drive."

Across Canada, the so-called "legal limit" defined by the federal Criminal Code, is a blood alcohol concentration (BAC) of 80 milligrams of alcohol per 100 millilitres of blood (0.08%). This is the level at which a charge of impaired driving can be laid. A trial in court follows, usually months later.

But to half the provinces — British Columbia, Manitoba, Saskatchewan, Alberta, and now Ontario — the federal standard wasn't high enough to promote safety on the highways. All use a BAC of between 0.05 and 0.08 as a basis for penalties, without criminal charges.

To a third of the drivers stopped in Ontario since mid-December who had readings of 0.05, the new law has meant — along with the licence suspension — towing or storing charges for their cars.

But no fine is imposed, no charges can be laid, and hence no black marks appear on a driver's record.

"Of course, it's a double standard," said Mr McMurtry. "But in my view there's nothing philosophically objectionable about a (federal) standard that brings in criminal sanction and a higher (provincial) standard that does not."

In Metro Toronto, according to information published in the *Toronto Star*, 13.3% fewer alcohol-related charges were made during the Christmas season campaign this year compared to last, even though 22% more cars were stopped. Accidents involving alcohol dropped 19.6% from last year. And 96 drivers were penalized under the new law.

Public awareness may have been heightened by reports on Parliamentary debate on the bill, and by a concurrent poster campaign run by the attorney general's office: sheetcovered corpses laid out on a dark highway with the simple message "Feeling no pain."

Will this promising start be maintained? Addiction Research Foundation scientist Evelyn Vingilis discusses the possibilities on page 2.

Nurses as addicts: A special report —Page 16

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NEWS

Briefly...

Moscow moonshine

MOSCOW — When the price of vodka rose 10% last fall, stores began running out of yeast. Now, with most of the yeast gone, bootleggers are turning to tomato paste. The recipe? Combine 10 pounds of sugar, 2½ pounds of tomato paste, and 5 gallons of water. Ferment for three weeks, then boil for a few hours. The resulting gallon of 60-proof moonshine costs $10, while the same amount of 45-proof vodka sells for $71.50 in state stores. "Aside from the price, the best thing about *samogon* (moonshine) is it doesn't give you a hangover," commented one Muscovite.

Ad rule overturned

OKLAHOMA CITY — A federal district judge here has overturned a 20-year-old United States law banning television advertising of alcoholic beverages. The reason: it violated free speech. To the state's argument that the advertising ban was intended to reduce alcohol consumption, Judge Lee West replied: "Consumption of alcoholic beverages in Oklahoma has increased substantially in the last 20 years despite the ban on advertising of such beverages."

Pot mart

FT LAUDERDALE, FL — Only hours after setting up a "marijuana supermarket," undercover agents here made six arrests and confiscated $195,000. The first three customers to the warehouse, which was loaded with one-and-a-half metric tons of marijuana, arrived with two cars and $130,000 in cash. After loading up one car, police arrested the three for marijuana conspiracy and trafficking. The other three arrests followed just as easily. "It was a heck of a grand opening," observed Police Chief Leo Callahan.

Girls catch up

NEW SOUTH WALES, AUSTRALIA — Although there has been decreasing use of alcohol and most drugs among teenagers in New South Wales in the past 10 years, girls are catching up with boys in usage levels, concludes a report by the NSW Drug & Alcohol Authority. The study suggests several possible causes for the decrease: "more effective health education methods, the inevitable decline in the fad for taking certain drugs, increased conformity reflecting a more general conservative swing in the population, the effects of legislative changes, and the effects of declining relative disposable income amongst the adolescent population." The report recommends drug education programs concentrate on drug use by females.

Charge dropped

TORONTO — Charges of cocaine possession against James Alexander McQuirter, head of Canada's Ku Klux Klan, have been dropped (**The Journal**, Jan). When the police analyzed the two ounces of white powder found in Mr McQuirter's car, it turned out to be "not an illegal substance." But the other charge — possessing an unregistered and restricted weapon — still stands.

Bill 178 is swift, severe, but...

Problem drivers are difficult to catch

TORONTO — Ontario's Attorney General Roy McMurtry has high hopes for the controversial Bill 178 on drinking and driving (page 1).

But researcher Evelyn Vingilis of the Addiction Research Foundation (ARF) has some doubts. She will be evaluating the effects of the new law for a year — conducting phone surveys to determine public perception of drinking and driving, and studying police records of accidents, injuries, and fatalities to find out if there is a trend.

"In almost every type of combined enforcement and education program, there seems to be an initial impact," Dr Vingilis, told **The Journal**.

"But after a while, people realize that the risk they perceive is different from the real risk of getting caught and they go back to their old habits."

Dr Vingilis, whose research was studied by the government in preparing Bill 178, says there are three criteria for effective deterrence: the severity of the penalty, the swiftness of the penalty, and the certainty of getting caught.

The penalty is certainly swift in the new 0.05 law, said Dr Vingilis.

So is the severity: "I would imagine many people would consider it much more severe to lose their cars for 12 hours than to go to court nine months later."

The problem is the certainty of getting caught. Spot-checks, if used widely enough, could increase the chances of drivers being stopped, and police can also be trained to improve detection of impaired driving, Dr Vingilis said.

The best indicator of alcohol-related accidents, she said, is the number of nighttime, single-car crashes.

Although four provinces have laws similar to Ontario's, few statistics are available on their effectiveness. Only British Columbia published an evaluation, in 1980. Although nothing could be said about alcohol-related accidents, injuries, and deaths, there was a decreased trend in total fatalities.

At the end of the year's evaluation, the legislation will return to the Justice Committee for assessment. Said Mr McMurtry, that will provide "an opportunity for the public or anybody else to consider the effects and the value of the legislation."

Whatever the results of the evaluation, it is unlikely that the federal Criminal Code limit of 0.08 will be lowered, he said.

"I'm not satisfied, at this point in time, that 0.05 should be made a criminal offence. There's a helluva difference between a criminal offence and something that is of a regulatory nature," Mr McMurtry told **The Journal**.

"But some people are pressing for this," he continued, "and my attitude at the present time is simply to encourage public debate and dialogue."

Jatinder Khanna, pharmacologist at the University of Toronto and the ARF, says fewer generalizations can be made about the effects of a 0.05 alcohol level than 0.08.

Vingilis: initial impact

"Some individuals begin to show impairment at 0.05. It's a marginal area," Dr Khanna said.

"Some will be impaired at that level, others won't. It depends on body weight, on individual responses to alcohol, on previous drinking history, on a host of factors — we don't even know all of them yet."

But between 0.05 and 0.08, said Dr Khanna, a "sharp increase" in impaired reaction times and ability to judge speed occurs.

To some people, however, the numbers are less important than the possibility of misuse of police power.

During committee hearings when the bill was introduced, Alan Borovoy, general counsel for the Canadian Civil Liberties Association, expressed concern that "random" checks might not be truly random.

"When they're stopping people, blacks and whites, men and women, gays and straights, and Fords and Cadillacs (should) have an equal chance," he told the committee.

CAF mapping outs its future

TORONTO — By 1985, more Canadians should know what the Canadian Addictions Foundation (CAF) is. "That's when CAF will begin running an annual National Addictions Week in Canada and when it will co-sponsor a major conference of the International Council on Alcohol and Addictions (ICAA), in Calgary.

In the meantime, CAF will continue to take stands on public issues and strengthen its financial base — with the aim of becoming "Canada's national voice in the field of addictions."

This was the consensus of the CAF board of directors, who met here in January at the Addiction Research Foundation (ARF).

Already, during the six months Ross Ramsey has served as CAF president, the organization has changed.

"The thing I feel most pleased about is that we've gone from a fairly large deficit position to a balanced budget," Mr Ramsey, also assistant executive director of the Alcoholism Foundation of Manitoba, told **The Journal**.

The $18,000 deficit was wiped out by $12,000 raised at the CAF's national conference in Newfoundland last summer (**The Journal**, Aug. 1981) and $6000 from both a Manitoba regional meeting and private donations.

In line with CAF's new fiscal awareness, last November it began acting as a distributor for ARF educational materials. Books, pamphlets, videos, films, and other resources are now available to CAF members at a 10% discount.

Ramsey: a national voice

"This is both a service to our members and a source of money for the organization," Mr Ramsey said. "Since we get a 40% discount from the ARF, we realize a profit of 30%."

CAF members may also subscribe to **The Journal** at a discount.

Last fall the organization took its first advocacy position, coming out against federal plans to decriminalize possession of marijuana. The position was in the form of a letter to Federal Minister of Health Monique Begin, with copies to the 10 provincial ministers of health. (**The Journal**, Jan.)

"The board members responsible for drawing up this position felt that if the government decriminalizes possession, the message the public will receive is that it's okay to use marijuana. CAF took its stand on the basis of health concerns," said Mr Ramsey.

CAF also offered to assist the government in setting up a public education campaign on the health risks associated with marijuana, he added. (An opinion poll of members conducted afterwards showed about 60% supported the CAF position.)

For the future, Mr Ramsey's "number one priority" is to raise about $30,000 to support a full-time staff position.

"We have lots of good ideas about what this organization can do," he said, "but right now, having one full-time person would sure help."

At present, Vernon Lang, a private consultant, serves as part-time executive director, and there is a bilingual office in Ottawa. Officers of the organization, including Mr Ramsey, are volunteers.

One idea for the future is for CAF to undertake some type of national accreditation program in the addictions field. A CAF committee is studying the feasibility of this proposal.

"There's a real need for the same professional standards to apply across the country, and in my opinion CAF is the natural group to get this done," said Mr Ramsey.

CAF, established in 1962, is a national association of counsellors and other professionals in the field of addictions. Some, but not all, are employees of provincial agencies. A newsletter and a national membership directory are two ways for members to communicate with each other. Another is the conferences CAF sponsors each year. (This year, a symposium on youth will be held in New Brunswick in May, and the CAF annual meeting will take place in Yellowknife in June.)

Membership fees, currently $10 per year, are about to be raised because, according to Mr Ramsey, "we now have some real benefits to offer our members."

Women are at much greater risk than men from socially acceptable amounts of drink

LONDON — Women who drink the equivalent of two and a half pints of beer, four glasses of wine, or two double measures of spirits daily may risk developing liver disease, an expert claims.

The warning comes from Dr John Saunders of the liver unit at King's College Hospital.

Confirming earlier reports that women are at much greater risk from socially acceptable amounts of alcohol than men, he says: "Women should drink only half the amount that their boyfriends, husbands, or male colleagues drink and in no circumstances should their consumption exceed 40 grams per day."

Writing in *London Alcohol News*, journal of the London Council on Alcoholism, he says one of the most disconcerting trends in recent years has been the great increase in drink problems among young people and especially among young women.

"Twenty years ago, alcoholic cirrhosis (a potentially fatal liver disease) was almost exclusively a disease of middle aged and elderly men," he says.

"Now 40% of patients are women. Counselling services are also finding that a much higher proportion of their clients are women compared to 10 to 20 years ago."

He adds: "There is increasing evidence that women are constitutionally unsuited to drink as much as men and more susceptible to its toxic effects.

"From studies where the risk of developing liver disease has been examined in relation to drinking habits, we know that women may develop cirrhosis if their daily alcohol intake exceeds 40 grams, equivalent to two and a half pints of beer, four glasses of wine, or two double measures of spirits, amounts which many women would regard as socially quite acceptable.

"Men are not at significant risk until their daily intake exceeds 80 grams."

Dr Saunders points out that cirrhosis develops more rapidly in women than in men. It takes an average of 13 years' excessive drinking for a woman to develop symptoms whereas a man would take an average of 22 years.

NEWS

Claims of increased teen drinking are unfounded

By Harvey McConnell

WASHINGTON — Teenagers' use of alcohol is not rising as their marijuana use drops — it's just more open now than it was a few years ago.

Lloyd Johnston, PhD, program director of the Institute for Social Research, University of Michigan, said that since researchers started measuring teenage substance use in 1975, "with alcohol there has really been a dramatic stability compared with all the other drugs, which are showing substantial changes up or down."

Dr Johnston's yearly measurements of high school seniors' substance use for the United States National Institute on Drug Abuse has shown that marijuana use peaked in 1978, and has dropped statistically since then.

The latest report, due early in the year, is expected to show this trend is continuing.

He told a conference of the American Council on Marijuana: "Something you hear widely stated is that there has been an increase in alcohol use which is replacing the real decrease in marijuana use. Our statistics do not indicate that at all.

"We show that daily alcohol use has remained around six percent since 1975. I think that one of the things that may have happened is that alcohol use has become more readily practised in public. That may have come about because of the whole drug culture and the increasing freedom to do things in public which had been done in private before."

Dr Johnston told **The Journal**:

Johnston: a dramatic stability

"This is strictly a hypothesis but I think it has some credibility. I have no reason to think the figure will change when we finish correlating our latest study.

"That, however, is not to downgrade the problem because alcohol prevalence is still extremely high. It just hasn't changed much because it has always been high, that is the major thing.

"One area in which we did see an upward drift, and this is very modest compared with most other changes, is in the number of kids who basically got drunk in the last two weeks of being surveyed, and this rose from 37% to 41%.

"However, this is not anything like the public perception and I don't think that when marijuana came on the scene it really displaced alcohol. Alcohol use has moved relatively independently and added marijuana use to it."

Dr Johnston said yearly surveys of some 17,000 seniors in 137 high schools over the years have shown that marijuana use is correlated with the use of other psychoactive substance they have measured, including caffeine, nicotine, and alcohol.

Among daily marijuana users a large number are daily drinkers, and some 60% are daily cigarette smokers.

He said this last fact is of considerable public health interest because the youths run risks, not only from cigarettes, but also from marijuana, of effects which could be multiplicative and not additive. "And I think the long term effects, such as (on) the lungs, could be quite substantial for this population."

Dr Johnston said marijuana use among the high school students peaked in 1978. Over the next two years the proportion reporting any use in the month prior to the survey dropped slowly but steadily, to 34% from 37%, and, more importantly, the proportion reporting daily use dropped to 9.1% from 10.7%.

Dr Johnston said that as the team has been collecting information on this population for some years "we can do a lot more than simply guess" what is happening.

One factor which has not changed is availability; since 1975 about 90% of each class has said marijuana is very or fairly easy to obtain. And price is not a deterrent.

The indicator which has shown the largest change is the belief among young people about the harmfulness of using certain substances. The researchers have observed a substantial increase in harmfulness perceived to be associated with regular marijuana use, and this concern is now radiating out to include occasional use, as well.

On a long and comprehensive list of reasons the young people could check as contributing to their decision not to use marijuana any more, 71% were concerned about possible physical effects, and 68% were concerned about psychological effects. There is also specific concern about loss of energy reported by 41% of former users.

Aside from health concerns, peer norms are shifting; seniors not only disapprove of regular marijuana use, they also believe their friends disapprove of such behavior. There appears, as well, to be decreased acceptance of occasional or even experimental marijuana use.

Dr Johnston said that while the situation with marijuana seems to be improving, "I do not want to leave the impression that the problem is near to disappearing. The downward trends are slow and starting from a very high base."

It should be remembered that among the high school seniors surveyed in 1980, 60% reported at least some experience with marijuana; 49% had smoked it in the last year; 34% were current users, and 9% were using on a daily basis.

NAAC names chief

WASHINGTON — David Oughton has been chosen executive director of the United States National Association of Alcoholism Counsellors (NAAC).

Mr Oughton, who took over the post in December, has a wide experience in the alcoholism field, including work with ALMACA, the Association of Labor-Management Administrators and Consultants on Addiction. However, he says he considers his talent is more as an administrator than a counselling expert.

He said in an interview with **The Journal** that one of the major problems he would deal with in NAAC "is building agreement with two rather diverse groups, the alcoholism counsellors and the drug abuse counsellors."

Some members of NAAC believe the organization should encompass both groups. "After all, in many state associations you have both working together, and in my opinion it is an emotional issue.

David Oughton: one major problem is building agreement

"However, we have to remember people who are recovering alcoholics had alcohol as their drug of choice, and that is where their bias is."

Before moving to NAAC, Mr Oughton was general manager of the magazine, *Running Times*.

Soothsaying's simple — take Kathy for example

By Wayne Howell

Seers and prophets who predict the future course of human events are often looked upon with wonder and awe. But it's really no great trick to predict the future; all you have to do is look at contemporary trends and follow them to their logical conclusions. A little sifting through the cultural detritus of modern civilization and presto, the future unfolds before you. For instance, I can see the future of little three-year-old Kathy with great clarity.

Little three-year-old Kathy was recently described in an American publication as sitting on the floor of her parents' New York apartment practising rolling a joint. When her mother entered the room the tyke proudly held up an empty tube of white paper and called out, "Look Mommy, just like you and Daddy smoke." Right on the spot, the article says, Mommy and Daddy swore off pot.

But what did the future hold for little Kathy? Well, you have to admit it was a cute story and it had a message for young marrieds who had got into Family but hadn't quite got out of 1960-style habits. When Mommy and Daddy told little Kathy's story to local TV talk show hosts in the Big Apple (who liked to get some socially constructive material to counterbalance the showbiz trivia that filled out the rest of the time between commercials) the eyes of the talk show hosts would moisten with tears. And Ed McMahon actually cried when Mommy and Daddy, with little four-year-old Kathy on Daddy's knee, made their national debut on the Tonight Show. Johnny, too, was touched.

National network exposure on the talk shows certainly helped make the Little Kathy Dolls the hit they were, outselling Barbie Dolls in 32 states during the 1983 Christmas season. But what with the TV exposure and the Little Kathy Dolls and the Little Kathy Comics, Kathy's life became complicated. Even though she was now living in Washington (where Daddy had been hired as a special consultant to a national drug abuse program) and where her Georgetown playmates were used to celebrity children of one kind or another, little Kathy stood out as someone special. She couldn't go anywhere without being recognized and fawned over. There were days when she wished she'd taken that stupid tube of paper, shoved it in her mouth, and eaten it, and never said anything cute.

She tried to communicate her feelings to Mommy and Daddy but they were never around. Daddy was always away doing celebrity speaker gigs at drug conferences. And Mommy was spending more and more time with Hiram Welp, the lawyer who handled the dolls and comics and other paraphernalia of the Little Child Shall Lead Them Foundation. Frightened and alone, little Kathy didn't know where to turn.

The story that little Kathy — *the* little Kathy — had become a heroin addict at nine years of age left all of Washington agog. And, when the copyrighted story by ace investigative reporter Janet Woodstein of the Washington Post was fed into the AP wire it caused a national sensation. A tearful Phil Donahue sent flowers and said that despite this personal tragedy he was still sticking by little Kathy and she was welcome on his show anytime.

The story wasn't true, of course. Nine-year-old Kathy had just been putting the ingenuous reporter on, although it was true that she had fallen in with a group of Georgetown kids with a bad reputation and one of them did know a man who did use heroin. But after the reporter got the Pulitzer prize for the exposé, well it just seemed like nit-picking to question the facts. And anyway, that was not the kind of story they wanted to hear on the talk shows where she had become a hit once again, this time going on without her parents. It was kind of fun to be in the limelight again.

At least it was until the cute black child-actor she went on with started trying to hog the show. Pushy little brat — why he had never even been a heroin addict, and he wouldn't be there at all if the Little Child Shall Lead Them Foundation had not insisted on him to provide racial balance (heroin being a problem in the black community and all that) and to boost the ratings. And the ratings were important, as Hiram Welp was forever pointing out to Mommy, because the designer jeans market was a tough one, and Little Kathy Jeans had to compete with Daniel Hechter Jeans, André Michele Jeans, and Pierre Cardin Jeans, not to mention Calvin Klein Jeans. The more TV exposure you got, the better. Still and all, Kathy couldn't hack the scene-stealing Gary Coleman clone and was overjoyed when Daddy announced at a drug conference in Dallas that he too was a reformed user of the big H, because then they could do the talk shows together, just like old times, although she was now too big to bounce on his knee.

They made an attractive pair, putting some viewers in mind of father John and daughter Mackenzie Phillips, who had done the family-drug-confessional-trip so well back in the early 1980s. Needless to say, the whole thing gave Daddy a higher profile and more credibility on the lecture circuit. And the publicity didn't hurt the jeans sales at all: in the summer of 1990 Little Kathy Jeans outsold Calvin Klein Jeans in 32 of 44 upscale market areas across the land. the 'little Kathy logo' sewn on the right back pocket became a familiar sight on well-heeled haunches across the land. (It was a good logo — but not a great one. Originally Hiram Welp had wanted to use the logo of the Addicition Research Foundation on Little Kathy Jeans but when the marketing manager of the Little Child Shall Lead Them Foundation approached the ARF with a request for rights to use the logo in return for 10% of gross retail sales in perpetuity, the stuffy provincial institution turned him down.)

By the summer of 1994 little Kathy had become pubescent and her Lolita-like appeal prompted the American Lung Association to feature her — in her jeans of course — in a series of anti-smoking ads aimed at teenagers. This resulted in a Brooke-Shields-brouhaha and the campaign was eventually scrubbed by narrow-minded puritans. But this dark cloud of resurgent Calvinism had a silver lining. The controversy got little Kathy on the cover of *People* magazine. The exposure couldn't have come at a better time, for Hiram Welp had just launched Kathy Klothes. The time was right to break out of the designer jean market and to get into producing an entire line of clothes for the upscale youth market. By 1996 Kathy Klothes were well established, edging out Bill Blass originals in many of the better shoppes, leading some disgruntled ARF researchers getting by on niggardly government handouts to say, "we had our chance and we blew it."

Kathy loved the world of high fashion: the excitement, the glamor, the parties, the high life. She took to it like a fish to water. So it was not surprising that when a Los Angeles police constable apprehended her as she was slipping behind the wheel of her Mercedes on Rodeo Drive he discovered 3.2 grams of cocaine in her Gucci handbag. Of course this Louise Lasser-style bust did her no harm. The movie of her rehabilitation — with little Kathy playing herself of course — was a great success. It came out in 2001, and was called, "A Spaced-Out Odyssey." It was kind of like old times, going on the talk shows and promoting it.

NEWS

Pot totally incompatible with learning

WASHINGTON — Every element of learning is incompatible with acute intoxication or the chronic mental changes that marijuana can produce, says Sidney Cohen, Neuropsychiatric Institute, University of California at Los Angeles.

And one of the most unfortunate developments of the past decade in the United States has been the increasingly young ages of people using marijuana, Dr Cohen told a conference of the American Council on Marijuana (ACM) here.

He said: "The society that fails to teach its youth the knowledge necessary for their psychological and social development and maturation must decline." Learning is central to growing up.

Learning is impossible without remembering and a prepared mind must be capable of receiving and evaluating what is being learned.

"That great gift of humankind, the ability to sort and integrate information, should not be dulled."

Dr Cohen said it has been well established that marijuana can interfere with the ability to form new memories, with immediate recall most affected. This is why many people intoxicated by marijuana stop in the middle of a conversation — they cannot remember what they have just said.

As surveys show, many young people use marijuana during school hours. The "knocking out of immediate recall will make what might be learned incomplete, with gaps in the informational content." What chronic heavy use of marijuana does to the memory process has not yet been determined, he said.

Sensory changes are the most sought-after effect from marijuana.

Dr Cohen: "Time may slow down, and sensation is altered from an amplification of sensory input to illusions and even hallucinations. These alterations may be entertaining, but new learning is distorted."

He noted it is not surprising that a person acutely intoxicated from any substance has reduced motivation and interest in goals. Young people seem to become more vulnerable from smoking marijuana than adults, perhaps because they do not have the compensatory mechanism for dealing with the mental shifts induced by chronic use.

A real loss of motivation is evident in many young people, although not all heavy marijuana users develop it. Nor should every instance of motivational loss be attributed to cannabis, he said.

"Adolescent depression can present a similar picture. It is the pharmacologic effect of prolonged marijuana use combined with a measure of psychological vulnerability that, together, result in the amotivated state.

"In my opinion, the condition is almost always reversible, but it can take months, even years, of abstinence from marijuana for the intellectual blunting to dissolve entirely."

Practice is vital to learning. "We must rehearse and repeat the verbal information or behavioral skill before it becomes a part of our permanent repertoire of knowledge and behavior." With the juvenile marijuana user practice time is not available.

Dr Cohen said there is one last factor. Learned behavior tends to be perpetuated if it is rewarded; "the problem with marijuana use during the formative years is that marijuana takes over the reward system. Marijuana becomes the reward."

Incentive to learn, to study, and to excel fades because the rewards of a drugged state are so easily obtained. The casualties have not been counted and only impressions are available of the results of protracted marijuana use in the younger age groups.

"Young people must be informed even though many will not listen. The parent and peer-action groups, to me, are the most promising prevention programs in sight.

"Anything that can be done to accelerate return to an undrugged state for youth, should be."

Cohen: rehearse and repeat

Information, not rhetoric, is key

Schools must help solve drug abuse problems

WASHINGTON — Support for public education in the United States hinges on the public school system's solving the problems of drug use.

Robert DuPont, president of the American Council on Marijuana (ACM), said: "Not to face that problem, and to see it as irrelevant, or somebody's else's problem, or society's problem, is to run the risk, it seems to me, of a very substantial and continual erosion of public support.

"Turning the coin over, solving the problem will go a long way toward building the kind of public support we need for public education in this country."

But a solid information base is key, Dr DuPont, a former director of the US National Institute on Drug Abuse, told a conference here of the ACM.

"We must not get so carried away by our rhetoric that we don't pay attention to the facts; this is one of the issues which I think has kept us from being more effective about drug abuse in the last decade."

Whatever their stance on drugs most people agree certain substances should not be used by young people. Such organizations as the National Organization for the Reform of Marijuana Laws, the Tobacco Institute, the Distilled Spirits Association, and the Brewers Association agree young people should not use marijuana, tobacco, or alcohol.

"Thirty percent of all premature deaths occurring in the United States today are premature because of alcohol and tobacco. Nothing compares with these as problems in our society," he said.

He said drug use is uncommon before the age of 12 years and, after the age of 20.

"We are talking about a window of time, a period of vulnerability which is very small in the life cycle, very small."

Experimentation is the norm among teenagers and their first use of drugs convinces them they are not bad for their health and they will have no problems, he said.

Occasional use is followed by regular use and then dependence in certain cases. This varies from one drug to another.

He said a major problem in conveying messages about drug use is that "consequences are delayed, whether addiction, or lung cancer, or any other consequences." This provides a problem in communicating to young people. They see no immediate signs of their own vulnerability.

"Every drug abuser denies the consequences of his use, the levels of his use, and the frequency of the use. The user is always the last to know what the problem is with the drug, and I don't care what the drug is, or who the user is. It's very unusual for a person dependent on any drug to seek treatment for that drug on the basis of some self-perception of dependence."

Denial is linked to pleasure. "Anything that will produce pleasure for any of us — then we are not going to respond very favorably to somebody who wants to take it away."

The crucial point is teaching young people that their decision to experiment with any drug is a fateful one and not to be entered into lightly. "Their perception they can handle it may be true. But if it is not true, the consequences for them could be disastrous, and they may not have a chance not to use it until a long way down the road."

Dr DuPont said this is a major reason why there must be social control.

It may be not much can be done about the problem of denial, but if any serious effort is to be made to improve the quality and duration of young people's lives, it is the most important issue facing us today, he said.

RESEARCH UPDATE/ Austin Rand

Organic impotence

Chronic alcoholism interferes with the basic mechanisms of erection, suggests a study of the patterns of nocturnal penile tumescence (NPT) in 26 sober, detoxified male alcoholics, with an average age of 40. NPT involves involuntary erections which occur during REM sleep in healthy males from infancy until old age. In cases of impotence, decline in nocturnal penile tumescence is used as an indicator of organic rather than simply psychological problems. In their study, Drs Scott Snyder and Ismet Karacan of Houston found the NPT of detoxified alcoholics involved a far smaller number and shorter duration of full erections than was the case with healthy controls, and a greater number of NPT episodes of semi-erection. While the mechanism of action is not clear, Drs Snyder and Karacan note that vasodilation of the vascular system of the penis depends on activation by parasympathetic nerves through the action of acetylcholine. Ethanol, they note, reduces both release and synthesis of acetylcholine. In addition, chronic alcoholism may result in degeneration of axons and destruction of their myelin sheath.

Psychosomatic Medicine, 1981, v. 43: 423-428.

Height and passive smoking

Passive smoking at home seems to affect the height of children, indicates a study using data on 1800 children from the British National Study of Health and Growth. Researchers from the department of community medicine, St Thomas Medical School, London, found there was a strong inverse relationship between the height of children aged five to 11 and the number of people at home smoking five or more cigarettes per day. "The association . . . cannot be explained by smoking in pregnancy," the researchers note, "because adjusting for each child's birth weight did not eliminate differences in height between the groups." The size of the effect — one cm or between one-third and one-half inch, on average — is similar to that suggested by data from a Cleveland study, which also found an association between the number of smokers in the home and shorter stature of six and seven-year-old children.

British Medical Journal, 1981, v. 283:1363.

FAS can hit early

Fetal alcohol syndrome can be produced by as little as one or two sessions of heavy drinking early in pregnancy, suggests research from the University of North Carolina, Chapel Hill. The study involved giving mice, which were seven days pregnant, binge doses of alcohol on two consecutive days. The effects, closely resembling malformations seen in human FAS babies, included microcephaly, eye defects and craniofacial malformations, with at least one defect appearing in nearly 50% of offspring. The doses and timing in the study corresponds roughly, the researchers say, to two consecutive days of heavy drinking for a woman who is three weeks pregnant. "Many women are not aware of their pregnancy at this stage. Those who are aware may not realize that social or binge drinking so early in pregnancy may be as deleterious to the embryo as constant heavy drinking." They noted a previous study has shown there is a significant relation between FAS-type abnormalities and alcohol consumption in the month preceding recognition of pregnancy.

Science, 1981, v. 21:936-938.

Smokers' allergies

Smokers seem to be at higher risk of developing allergic reactions when exposed to potential allergens in the course of their daily work, suggests a Swedish study of workers in the pharmaceutical and coffee-roasting industries. Researchers from the University of Uppsala found that among pharmaceutical workers exposed to isphagula powder, a strong allergen used in bulk laxatives, smokers were five times as likely to develop allergic symptoms. Similarly, skin testing of coffee processing workers found that the great majority with allergic reactions were smokers. Also, smokers were much more likely to have already developed symptoms, including nasal and eye inflammation, skin problems, and asthma.

British Medical Journal, 1981, v. 283:1215-1217.

Alcohol ups blood pressure

An Australian study of 491 healthy working men has found that increased consumption of alcohol is accompanied by progressively increased blood pressure. The data indicate that three or more glasses of beer per day — yielding roughly 30 grams of pure alcohol — produce a three-to-four fold increase in the prevalence of both systolic hypertension (greater than 140 mm of mercury) and of diastolic hypertension (more than 90 mm of Hg) above the prevalence in teetotalers. Noting that another Australian study has shown a linear relationship between alcohol consumption and both systolic and diastolic blood pressure, L.J. Beilin and colleagues from the University of Western Australia suggest that "even those who might regard themselves as moderate social drinkers are at increased risk of hypertension . . ." They add, however, that a reduction to one or two daily drinks would substantially reduce such risk and at the same time maintain any protective effects that alcohol consumption offers against coronary heart disease.

Lancet, December 5, 1981: 1286.

Acetaldehyde and pregnancy

The higher the blood level of acetaldehyde reached during the metabolizing of alcohol, the greater the likelihood of aversive symptoms such as flushing and increase in heart rate and blood pressure, Arthur Zeiner of the University of Oklahoma told a symposium of the American Association for the Advancement of Science. These aversive symptoms may partly explain why pregnant women tend to decrease their alcohol intake, he said. "When women get pregnant, they tend to lose their appetite for alcohol, not so much because they are concerned about FAS, I think, but because for many it becomes aversive to drink alcohol. The probable basis for this change is that hormonal factors are leading to increased levels of acetaldehyde when they now have a drink." Zeiner added that women on birth control pills react in a similar way and have higher acetaldehyde concentrations than those who are not on birth control pills.

AAAS, Washington, January.

NEWS AND COMMENT

Governments should attack alcohol availability

By Peter Unwin

TORONTO — Government control of alcohol availability has been neglected as a response to heavy drinking, and lacks the coordination needed to make it an effective policy.

This theme underlies a report delivered by Norman Giesbrecht of Toronto's Addiction Research Foundation at a conference on control issues in alcohol abuse prevention, in Charleston, South Carolina.

Dr Giesbrecht says in the report that despite support from researchers, control methods in North America have fallen into disfavor at the policy making level in recent decades.

"Governments and the liquor industry (which generates substantial tax revenue for government) presently do not see advantages in the control perspective."

The control perspective is based on evidence showing a decline in deaths from cirrhosis of the liver whenever the accessibility of alcohol is curtailed. The report maintains control measures, while causing a "minor inconvenience for many moderate drinkers . . . need not preclude or restrict freedom, and are expected to lead to major preventative benefits for a minority."

Pointing to government intervention in other areas such as food, drugs, and smoking regulations, the report recommends governments take a more determined stand regarding alcohol availability.

"It has been suggested," says Dr Giesbrecht, "that currently Liquor Control Boards have less to do with control and much more to do with marketing than may have been the initial intention."

Although control measures have been implemented in pricing, drinking age, and the number and types of outlets available, Dr Giesbrecht says the trend in Canada is definitely toward further liberalization. "Declining real price, lowering the legal drinking age, and widespread advertising can easily be interpreted as messages to the population that alcohol is a normal, safe, uncomplicated consumer item that should be consumed in greater quantities."

The report cites sophisticated, aggressive life-style advertising as a major roadblock to a consistent alcohol policy. While counter ads, depicting the hazards of alcohol abuse, exist, they are not as extensive or technologically developed as those promoting liquor, says Dr Giesbrecht.

The report suggests the formation of a high-profile alcohol policy committee to combat division between various interest groups within the provincial government. It also warns against further increases in alcohol availability.

GILBERT

"...what's needed in this area is a sharp analysis..."

Is drinking & driving really a problem?

By Richard Gilbert

Often in these columns I have opined about drinking and driving, as follows:

"A better strategy [than temporary licence suspensions for drivers found with between 50 and 80 milligrams of alcohol in each 100 millilitres of their blood] would be simply to lower the legal limit, meanwhile increasing the apparent probability of being caught."
(December, 1979)

"Two recent judicial decisions will make it very difficult for the police to secure a conviction based on breath-test evidence until Section 236 [of the Criminal Code of Canada] is amended."
(February, 1980)

"If we could substantially reduce deaths from motor vehicle accidents, which are about half of all alcohol-caused deaths, I might conclude that alcohol would be doing more good than harm."
(May, 1980)

"It could be made a crime to *supply* alcohol to a person in a public or private place knowing that he or she might be operating an automobile shortly thereafter."
(December, 1980)

". . . few drunken drivers intend to break the law . . . the law on drinking and driving is chiefly for the protection of the innocent, rather than for the punishment of the guilty, and therefore it can sustain respect even when it is being broken . . . the law on drinking and driving is manifestly popular . . ."
(April, 1981)

". . . it is within the power of government to reduce impaired driving by raising the cost of drinking and driving or by reducing the frequency of these behaviors in some other way. But government is unlikely to act in these ways, because drinking and driving are popular things to do."
(July, 1981)

On the strength of these opinions, and little else, I was invited last year to an exclusive think-tank on alcohol and traffic safety organized by the Traffic Injury Research Foundation (TIRF) for the Alberta Alcohol and Drug Abuse Commission. Twenty-one experts and I retreated for three days in November and December to a haven set in the snowy splendor of the Canadian Rockies. Our job was to answer this question: "Are new initiatives possible for reducing traffic accidents and losses due to alcohol use by road users, or must past actions to deal with the problem — based on traditional and largely ineffective approaches — be continued, with efforts perhaps redoubled?"

Frank paper

The scene was set by a remarkably frank, two-part working paper produced by TIRF staff. The first part, by Alan Donelson, had the title "Alcohol and traffic safety: Context, perspectives, and problem definition." Recent data were summarized; important questions were asked. I was struck by the following conclusions about the data:

1. Some 20% of drivers on the road at night in North America have been drinking.
2. During the period 1973-78, total traffic fatalities declined in Canada, but the proportion of fatally injured drivers who were legally impaired remained constant. (Alcohol consumption increased during this period.)
3. In Canada in 1979, alcohol *may* have played a causal role in 50% of the 4980 traffic accidents that caused death, in 25% of the 173,480 accidents that caused non-fatal injury, and in 5% of the 566,600 accidents that caused property damage only, in that these are the estimated percentages of the respective crashing drivers who had a blood-alcohol concentration (BAC) above the legal limit of 80 mg alcohol per 100 ml blood.
4. A daily drinker driving with a BAC of 90 mg alcohol in each 100 ml of his or her blood is no more likely to have an accident than an abstainer whose blood is (presumably) alcohol-free.

Dr Donelson asked some important questions and made some interesting points: "Should we give it [alcohol and traffic safety] up as an important problem and merely seek to treat the victims?" "Are the associated costs [of drinking and driving] simply the price society pays for doing business?" "Impairment [as measured in the lab] may not equate with unsafe." "The present law that prohibits driving with A BAC at 80 mg per 100 ml or greater may be perceived . . . as penalizing responsible drinking drivers." "Why do [most] drivers impaired by alcohol *not* have traffic accidents?" "It is questionable tht the increased risk of a traffic accident incurred by drivers with moderate BACs warrants *criminal* sanction."

Heady stuff

This was heady stuff for your columnist, who had imagined that he could remain forever comfortable in his unquestioning support of the conventional wisdom on drinking and driving. There was more to come.

The second part of the working paper, by Reg Warren, had the title "Lessons from the past and options for the future: A review of societal responses to the alcohol-crash problem." It comprised five parts and a postscript.

In the first part Dr Warren analyzed the "Alcohol Safety Community," noting that there are, in reality, two uncommunicating communities, the Research Community and the Countermeasures Community, with the two communities commanding, respectively, 0.5% and 99.5% of available funds.

The Research Community is characterized, said Warren, by ". . . a relatively widespread scepticism about the effort-as-a-whole . . . a growing conviction that meaningful reductions in the alcohol-crash problem are unlikely to be realized from a simple expansion of existing efforts . . . [and] an increasingly vocal antipathy toward the pretense that 'solutions' do exist, undoubtedly borne of a conviction that it is the very perpetuation of this illusion that is dysfunctional to the common mission."

The Countermeasures Community consists of individuals who are paid to produce solutions that work. They do this with enthusiasm and imagination, arguing that "the alcohol-crash problem exists *in spite of* their valiant efforts and their effective (albeit, underfunded) programs."

Vicious cycle

The Countermeasures Community, said Dr Warren, actually comprises many communities, each intent upon a particular solution to the problem of drinking and driving — focusing on problem drinking, focusing on problem driving, deterrence, making cars safer, making roads safer, etc — and each convinced that it is caught in a vicious cycle: ". . . the level of funding available is insufficient to effect a meaningful reduction in the magnitude of the problem; in the absence of such a commitment it is unlikely that evaluation outcomes will be favorable; in the absence of a favorable evaluation outcome, it is unlikely that the necessary level of support ever will be obtained."

In his next three sections Dr Warren reviewed the effectiveness of countermeasures, concluding that "no impaired driving countermeasure has been demonstrated to be capable of producing a sustained reduction in the magnitude of the alcohol-crash problem." But, he added, "viewed from the perspective of the Countermeasures Community . . . there are no ineffective programs — only ineffective evaluations." He gave a Toronto example: "RIDE (Reduce Impaired Driving Everywhere) has continued to expand in spite of evaluations that are uniformly described as inconclusive."

Dr Warren's fifth section ventured what may have been "only a half-hearted attempt to rejuvenate unwarranted hope." He called for "restoration of a sense of mission," for "a return to the concept that societally acceptable solutions can be found," and for a "comprehensive, systematic, coordinated, integrated and cumulative, long-term program of activities."

Victim drinkers

The most interesting part of Dr Warren's share of this working paper was his postscript, entitled "Impaired driver as problem, or impaired driver as victim?" Warren suggested that impaired drivers may be no more than an unfortunate result of society's attitudes about and approaches toward drinking and driving. If we all drink and we all drive, there's bound to be some overlap between the two; someone's going to get hurt and someone's going to be doing the hurting.

Likely candidates as hurters will be those among us who take risks. Warren had suggested earlier that serious accidents may be caused by people who "have a marked predisposition towards risk-taking." Because such people drink a lot and, moreover, drive after their drinking, they create the impression that the alcohol use caused the crashes. But the risk-takers might very well have crashed anyway.

Viewing the impaired driver as victim or, in Dr Donelson's words, as "simply the price society pays for doing business" leads two ways. One is to do nothing — or very little — and hope that people don't get too upset about the cost of doing business. The other, wrote Dr Warren, is "to attempt to work towards the development of a more idealized social structure."

As an earnest democratic socialist, I can warm to the notion of an ideal social structure; but, since alcohol would still have a place in my ideal world, I'm not sure that improvements of the kind Dr Warren was contemplating will necessarily get us very far with the alcohol-crash problem. Also, doing nothing is probably out of the question. There are too many relatives of the maimed and the dead for the problem to be swept under the carpet.

So much for the notion of impaired driver as victim! But the point is that it was raised at all. The TIRF people really wanted us to deal with fundamentals.

Unresponsive participants

Did the think-tank participants rise to the occasion, shocked by all this heresy? Unfortunately not. We sat for three days seriously expounding our pet and often bizarre solutions. I learnt a lot about why some people think as they do — why, for example, some experts think that the best solution is to make cars and roads so safe that nobody, just nobody, ever gets hurt. (The answer is that it seems to work, at least outside of cities, though the cost per saved driver can be amazingly high.) I learnt very little about what our priorities might be. In fact, prompted by Donelson and Warren's working paper, I began to wonder whether we had a problem at all.

The news reports of the meeting showed no legacy of the fact that its participants had been exposed to such a stimulating document. The Toronto *Globe and Mail* reported the conclusions of the conference as being that "there is a need for much tougher enforcement of existing impaired driving laws" and that "without a strong, long-term commitment to do something about the problem, we will be no more successful in the next 10 years than we have been in the past 10 years." No think-tank was needed to come up with these worn pearls of wisdom. Maybe what's needed in this muddled area is a really sharp analysis of the precise nature of the alcohol-crash problem, conducted by someone whose livelihood does not depend on the existence or continuation of the problem, whatever it might be.

Next month: Does the Liquor Licence Board of Ontario encourage excessive alcohol use?

FEATURES

Key to treating alcoholic VIP: no special favors

By Harvey McConnell

SAN DIEGO — Treatment of VIPs for alcoholism must be no different than treatment for any clients — but the ancillary world will bring the headaches.

Joseph Pursch, corporate medical director for Comprehensive Care Corporation, and former director of the United States Navy treatment at Long Beach, California, said there are also dangers for those who carry out the treatment.

Pursch: the grace of several years

"The danger is that of not only you taking yourself too seriously, but others begin to take you too seriously," he told the annual meeting here of ALMACA (the Association of Labor-Management Administrators and Consultants).

Dr Pursch, who has treated a number of well-known figures for alcoholism, pointed out that while the VIP has charisma and power, "guess who makes them VIPs? We do.

"There is no VIP who is made into one except by us, and sustained, except by us, just as there is no alcoholic who is not sustained in his problem with alcohol by all of us called co-alcoholics."

What makes the VIP different is the coverup. They are beyond job performance and ahsenteeism, and other facts of conventional working life. What brings them to treatment, finally, is if the coverup fails because someone cares, or the person can no longer tolerate the pain in themselves, or, as generally happens, they commit the unpardonable.

Dr Pursch said the unpardonahle is, for example, a high ranking military officer in West Germany who wanders across the horder into Eastern Europe during a drinking spree; a bank president who is caught shoplifting at an airport shop; politicians who are drunk on the floor of Congress; entertainers who can't go before the microphone; or actors or actresses who cannot perform before the cameras.

Doctors are caught because of patient complaints, lawyers for embezzlement.

"Pilots who are alcoholics almost never drink when they are flying, but becoming drunk and insulting passengers while they are deadheading is very common."

What's needed is intervention, and this can be difficult, he said.

"Every VIP is surrounded by sycophants whose main strength is a pathologically healthy self interest that has to be ferreted out quickly. These people demonstrate an amazing unwillingness to help, or unwillingness to risk what they now have, as long as this VIP stays that way."

What the VIP needs is the simple and best advice ever: "He or she simply needs treatment for alcoholism. And you cannot do that with the VIP unless you treat the whole shebang" — not only the family, but in the case of many VIPs, the bodyguard, or, as in a number of cases, the homosexual partner as well.

Dr Pursch said treating VIPs puts strain on the treatment facility and the staff. He is often asked by members of his staff why they have to put up with the hassle of treating VIPs when they are doing very well without them.

"As one of my counsellors said to me: 'Why do we need this? We are doing fine now. If we succeed, it's no big deal because we're expected to, and if we screw up, guess who screws up?'

"I said: 'Yeah, guess who? And he said: 'Yeah, I see what you mean. Skip it.' "

Dr Pursch said there is attention, if not criticism, from every quarter. If the VIP is well known by the general public, there can be an avalanche of mail, offers of gadgets and treatments, security problems, even a clogged parking lot, not to mention pressure from the press.

He has treated a number of Moslems from the oil rich Middle East; often, they turn up with an entourage "which seems to be made up of half the country's population."

Dr Pursch said that when a VIP is to be admitted to his facility, he does not tell the staff or patients until about 20 minutes before the person arrives.

"I tell them he is no different from any of them except he is a VIP. I talk about the VIP syndrome and tell them that anybody who comes through the facility does not get cured by Dr Pursch or any other director, but because of the milieu, because people heal people; doctors only stand by and collect a fee if they are lucky. We just guide patients."

The clients are told not to contact family or friends and staff are discouraged from having visitors for lunch.

Dr Pursch said there is inevitably one last battle with the VIP on the day of admission and it has to be won; the VIP client must live and act like any other client. There will be no special favors.

"That one last ditch effort is to show who is in control . . . If you lose that one, you can write it off."

Dr Pursch said that with a celebrity, he holds a brief press conference and explains the patient has been admitted for treatment and no further statement will be made until the day the patient leaves.

"You have to avoid the temptation to grandstand. Some of us would like to give morning press conferences. Part of me, at first, wanted to. But what do I say? The patient did well in an assertive group yesterday, or he has been using the pay telephone in the conventional manner?"

Dr Pursch said he is often called at home by fellow doctors who, at some time or other, have dealt with the VIP patient. Their fear is they will somehow be harmed by public statements or comments.

Dr Pursch reassures them they will not be mentioned. "What helps me in talking to them is that I often know that there but for the grace of several years go I. There are a number of chronically-ill captains who could be retired healthy admirals if I had done the right thing 10 or 15 years ago. Sometimes I didn't, and the fact that I know that helps me when my fellow doctors call."

Dr Pursch said that when the patient is ready for discharge, he does become involved in finding a suitable AA (Alcoholics Anonymous) group. He can do this more easily "because I am not in AA. I am not an alcoholic."

He tries to find a sponsor of the same sex, but older, with 15 to 20 years of sobriety in a sound program, who is both familiar with VIPs and has been in the VIP's field, and who knows the clay feet.

This procedure has brought him into conflict with AA groups but he sticks to his guns.

Dr Pursch said he recently ran into a wave of criticism for comments he made at a department of defence conference in Washington. ("I am no stranger to controversy because I speak from the gut.")

He felt he was talking to a large number of "no boat rockers" in the armed forces and civil service who use anonymity and confidentiality as covers.

Carrying confidentiality to the extreme is harmful to the client. Yet the counsellor or doctor has to push the issue.

"For example, I have dealt with a number of homosexuals in the navy. Now the doctor does not betray confidentiality, but the patient is not going to get well until he is willing to reveal this information. I push confidentiality with the patient until he or she is willing to relinquish it.

"Manipulative? All the world is manipulative and the men and women are merely the manipulators. As long as it is helpful and constructive you can call this a therapeutic encounter."

Dr Pursch said he believes EAP should mean "education and prevention."

"Treatment is not all that red hot, except for the one person who gets well. I tell you, we in the field don't educate enough."

He said many times he has started a conversation with a fellow airline passenger who turns out to be a high official in a firm.

The fellow passenger expresses fascination with Dr Pursch's work and expresses the wish that his corporation had such a program. Dr Pursch often points out that such a program does exist in the company and he knows the EAP director.

Everyone must be made aware of programs, he added, including high level officials.

Dr Pursch noted that "what I say in public shouldn't matter all that much. If your job rides on what some crazy expsychiatrist from the navy with a Yugoslav accent says, then you better reexamine your program.

"I am just a Joe-come-later who wasn't worried about alcoholism at all when many of you (in the EAP field) had been doing a good job for years."

VIPs who've been treated for alcoholism: (clockwise from top left) Alice Cooper, Betty Ford, Billy Carter, Rita Hayworth

Europe to attack roots of youth drug use, riots

By Thomas Land

STRASBURG — The governments of Western Europe are to emphasize prevention rather than punishment in their combined effort to combat the alarming increase of drug addiction among the young.

In the long term, the changing emphasis could lead to greater public investment in the medical, social, and education services as well as youth employment programs. The idea, approved at a ministerial conference of the Council of Europe, is to treat drug addiction as a symptom of crisis affecting the whole of society.

Drug addiction is now evident in every layer of West European society. Women and children comprise a rapidly growing proportion of the estimated population of 200,000 hard-core, largely young addicts in the 12 countries represented at the conference.

Recent youth riots in Europe can be traced to the same roots as the upsurge in drug problems, says the Pompidou Group

A dramatic rise of unemployment affecting the young coincides with the increase of drug abuse — involving mainly heroin, cocaine, and amphetamines — in Britain, France, Belgium, Denmark, West Germany, Italy, Ireland, Holland, Sweden, and Luxemburg, as well as Greece and Turkey, the so called Pompidou Group on drug abuse, attending the private consultations. Council of Europe Secretary General Franz Karasek declared: "Let's give work to our young people . . . and drugs will lose their attractiveness."

That may be an over-simplification, but it illustrates the shift of emphasis in collective official thinking away from punishment to prevention. The new approach is due in part to a penetrating study prepared for the Council of Europe by a group of eminent specialists analyzing the spread of drug addiction in the context of social change accelerated by the recession. Its conclusions appear to have been confirmed by a series of riots staged by the angry youth of many West European cities during recent months.

The study explores a wide range of social evolution shaping the pattern of acceptable behavior. The following are some of the trends identified by the study as having particular relevance to drug addiction:

- Medication — The emergence of the "pill-popping" society, in which health appears to be dependent on pharmaceuticals to help people to adjust to their environment by suppressing anxiety and depression, and to which, therefore, "magical" powers are attributed. As a result, children are presented with forceful parental models of evasion and abdication of responsibility.
- Conflict — the contradictory messages generated by a civilization in crisis. Traditional values previously safeguarded by family, church, and school are in decline while increased importance is attached to material prosperity.
- Frustration — inappropriate and impersonal education systems frequently impart useless knowledge and deny individuals scope to develop their personality and a valid choice of life-style. The rapid, recent growth of youth unemployment tends to discredit the education system in its role of preparing young people for the world of work.

In their report, intended to shape governmental policy, the specialists emphasized drug addiction was merely one manifestation of deep-rooted problems which also find expression in other destructive phenomena such as suicide and street violence. They called for a widely based program of prevention, including integrated action programs for the promotion of health, centred on schools but also involving the surrounding communities including parents, staff, and various local associations.

The Pompidou Group of the Council of Europe first came together in 1971 to seek a common remedy to the growing waves of drug addiction eroding the stability of European society.

NEWS

New breath test can spot anything and store it away in crystal form

By Pat Ohlendorf

WATERLOO, ONT — A new kind of breath analysis machine is hitting the streets in Canada and the United States. Since the instrument can detect any substance in breath, not just alcohol, it is expected to be as useful to hospitals as to police. Diabetics in particular should benefit, because the new machine can measure levels of acetone in breath quickly and precisely.

It can take "deep lung" samples from unconscious people and also can convert breath samples to tiny crystals for future use in court or for medical purposes.

The instrument (the BAC Breath Analyzer), invented by Dr Werner Adrian, optometry professor at Waterloo University, is a type of spectrophotometer. It identifies gas molecules by the rate at which they absorb infrared light. Conventional police breath analyzers detect alcohol by a chemical process involving sulphuric acid.

"I expect the new breath analyzer eventually to replace the chemical detectors police now use," Dr Adrian told **The Journal**. "For one thing it's faster and easier to operate because it's fully automated."

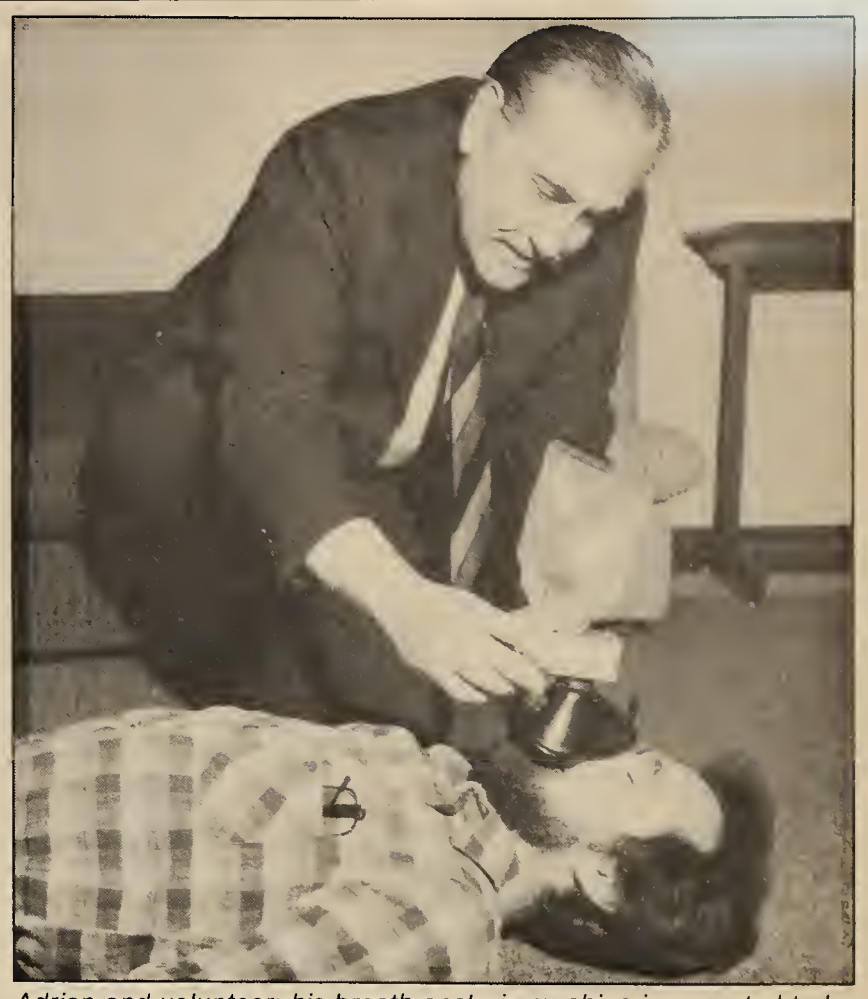
One demonstration model even has a built-in electronic speech synthesizer which tells subjects if they've had too much to drink.

Although Dr Adrian's device is more expensive than conventional detectors ($4000 compared to $1000), he believes it's more economical in the long run. "Every time you do a test with a chemical breath analyzer, you need to insert a new ampule containing sulphuric acid and potassium dichromate, which costs about four dollars," he said. Also, the corrosive action of the sulphuric acid shortens the life of conventional detectors.

The ability of the machine to store breath samples as crystals is an important advance. "Samples can be stored at present," said Dr Adrian, "but as the whole breath, in bags. We just store the ingredients of the breath in crystals."

Although police cannot use the new device to detect marijuana intoxicated drivers on the highways, gas chromatography on the stored crystals can reveal the amount consumed. THC (the active component in marijuana) cannot be detected in gas form because its infrared light absorption reading is too close to that of water (which occurs in great quantities as vapor in breath). But it can be detected later in the crystals.

Breath Analysis Computer (BAC) Systems, Inc, a company specifically set up to manufacture Dr Adrian's BAC Breath Analyzer, is currently producing about 500 of the instruments for police in Alaska, Virginia, and Maryland. Dr Adrian holds the patents for his machine and serves as consultant to BAC systems.



Adrian and volunteer: his breath analysis machine is expected to be useful to hospitals as well as police.

Garrison bunker mentality prevails, says Ontario lawmaker

Ottawa is too vague on pot laws

By Jon Newton

TORONTO — Ontario Attorney-General Roy McMurtry says press reports that he is spearheading an attack on controversial federal plans to ease penalties against the simple possession of cannabis products are untrue.

But, he told **The Journal**, he *is* seriously worried about the lack of information available on the dangers of cannabis abuse and is also concerned about the "garrison bunker" mentality prevalent in Ottawa. "Sometimes I think I'm dealing with people from another planet," he commented.

In early December Justice Minister Jean Chretien suggested proposals to slacken sanctions against the possession of marijuana and hashish during a three-day meeting of federal and provincial ministers of justice and attorneys-general.

Mr McMurtry was widely quoted as saying he was ready to lead an assault by all the provinces, except Quebec and Manitoba, against the reforms. "But," he said, "there has been a lot of inaccurate reporting. I've seen clippings saying I'm leading the opposition to the marijuana laws, which is quite inaccurate inasmuch as we support the basic thrust, but we're very much against some of the tentative suggestions which have been made.

"For example, we agree that possession of a small amount of marijuana for one's own use — so-called simple possession — should not be regarded as a criminal offence. However, we think there should be some record, perhaps like the ones we have under the Highway Traffic Act or the Liquor Control Act.

"Jail is not an appropriate penalty, but there should be some sort of sanction for simple possession, and if individuals want to flaunt it, I think the courts should be aware of it."

He said the federal government seemed to be having difficulty in understanding this, which is where reports of opposition originated. Reforms were badly needed, however.

Mr McMurtry continued: "The federal government is still very vague about their proposals. They've given us some indication as to where they're going, but we're having problems with arbitrary distinctions like, what amounts to simple possession and what amounts to having marijuana for the purpose of trafficking? We don't, however, have any difficulty with decriminalization as long as it's made clear exactly what this means and that it's tied up with a very, very significant public education campaign. We think the two must be very close together.

McMurtry: from another planet?

"Decriminalization is perceived by many people as indicating a lesser concern for the use of marijuana, and it's that perception about which the public mind must be disabused."

The law as it stands provides for fines reaching $2000, or up to seven years in prison.

A spokesman for federal Solicitor-General Robert Kaplan said the government will go ahead with the plans to soften penalties for simple possession, but he could not say exactly how this would be achieved, or give details of the public education program, which could go on for three years at a cost of about $1 million per year.

Of the December meeting, the spokesman said: "The minister of justice reconfirmed that it has never been the intention of the government to legalize possession of marijuana, but to reduce the current harsh penalties for simple possession to a more realistic level. Further, he reconfirmed that the offences of trafficking and importation of illicit drugs will continue to be serious criminal offences and will be vigorously prosecuted.

"Provincial ministers and the federal government share the same basic concerns and both levels emphasize the need for an information campaign to make Canadians aware of the dangers to health from cannabis use and of the serious consequences of a criminal conviction.

"Provinces expressed concern with the need to reform the legislation dealing with criminal records. Concerns were expressed that the reduction of penalties would lead to a perception that cannabis use is not harmful, and result in increased consumption. It was agreed that further discussion with the provinces would be desirable to identify the implications of any proposed changes to the legislation and to work closely in the implementation of appropriate information programs."

Political, financial climate taking toll on NORML

WASHINGTON — Membership in the United States National Organization to reform Marijuana Laws (NORML) has dropped to 6000 and the group is in serious financial difficulty.

Linda Lucks, a NORML director, told the organization's annual conference that most of the current $275,000 budget will be spent on soliciting new members by using the mailing lists of *Rolling Stone*, *High Times*, and the American Civil Liberties Union.

Ms Lucks claimed many potential members are scared off by the current political climate in the United States, and others are either unemployed or fearful of it, and cannot afford the annual $25 dues. Those considered hardship cases will pay only $15.

She said: "Ten years ago we thought marijuana would be legalized by now," adding, "Then came Reagan, and there we are."

Richard Evans, a Massachusetts lawyer, said 12,000 tons of marijuana is imported into the US each year "and God knows what type of mealy bugs and mites and slime are coming in with it." He said that current US policy creates "a severe threat to public health."

He said that at a conservative estimate, between $3 billion and $6 billion would be raised by taxes yearly if domestic cultivation was made legal. NORML has a model act which would allow states to license commercial growers, regulate sales, and level taxes.

Robert Pisani, a Washington lawyer, said the major impediment to legalization is the United Nations Single Convention on Narcotics, signed by 110 countries, including the US and Canada. "It is one of the most widely adhered to conventions in the world today. The only way to get rid of it would be to have President Reagan denounce it."

Jerry Knight, a financial writer for *The Washington Post*, said marijuana is a $20 billion industry politicians don't want to touch. Yet it poses a balance of payments problem comparable to that with oil.

Andy Rapoch of Ottawa, president of NORML in Canada, said "we are exactly where we were 10 years ago." He held up a 1970 headline: "Ottawa stands firm on softer pot law."

He noted that provincial attorneys-general are opposing a softer law, and the outlook for legislation is not good, despite federal promises a bill will be introduced.

California uses 'big stick'

Stiff laws for drunk drivers

LOS ANGELES — The state of California has passed stiff, new legislation to help combat the problem of drinking drivers.

Enacted January 1, 1982, the new laws require a convicted first-time offender to serve a two-day jail sentence, or face a licence suspension of 90 days.

According to Doug Schmidt, community relations officer, the main thrust of the new laws is preventive. "We're talking about white collar drivers who will now be facing jail time," says Officer Schmidt.

Under the old laws, patrolmen often saw their cases plea-bargained down to a fine. What the new laws will do is significantly reduce the amount of plea bargaining open to the offender. "I think now we'll see more incentive for the policeman to pursue drunk driving offences through the courts," says Officer Schmidt.

The new measures make it illegal to drive with a blood alcohol level of .10 (100 milligrams of alcohol in each 100 millilitres of blood) or above. Previously the law held .10 to be a presumptive limit only. The suspect was presumed to be intoxicated, but could refute the charge in court. Now a .10 blood alcohol level means mandatory conviction.

Another measure provides that, in felony drunk driving cases, it's no longer necessary to prove the suspect committed a specific violation other than driving while intoxicated. Now it is necessary only to establish the driver's actions caused the accident.

"A lot of people favor tougher legislation," says Officer Schmidt. "What you really want is voluntary compliance . . . but when you can't get that, sometimes you have to use a big stick."

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Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Addicted writers 'insightful beyond normal realm'

Does drinking stimulate creative endeavor?

Re: Lynn Payer's article, Drink: obfuscation, not inspiration, (**The Journal**, Oct 1981).

In my opinion, Donald Newlove said one thing correct when he told Ms Payer: "That the greatest writing is made out of loneliness and despair magnified by booze is an idea for arrested adolescents." The writers he was referring to were arrested adolescents.

Kerouac, Hemingway, and Lowry were incurable romantics and their unresolved adolescent omnipotence continued to delude them throughout their lives. They became cynical depressives which was also the inspirational force of Eugene O'Neill.

Alcoholism and other mood-altering chemical addictions have been the biochemical stimulation for most major literary works

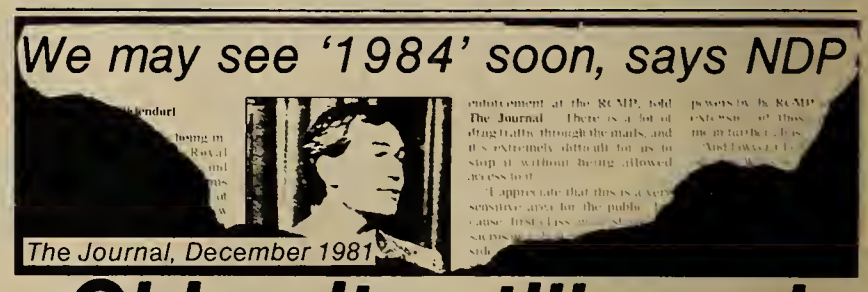
throughout the history of man and they'll continue to be. Conscious, or better yet, conscience-altering experiences crack through inescapable dimensions and are immeasurably motivating in spite of the consequences, which are usually known to the trespasser.

Malcolm Lowry's *Under the Volcano* is *must* reading for anyone working in the field of alcoholism. Lowry's gift to humanity is this frightful journey into his chronic alcoholism.

Ernest Hemingway intimated his true cynical feelings in *The Old Man and the Sea*. He wrote: "His choice had been to stay in the deep dark water far out beyond all snares and traps and treacheries. My choice was to go there to find him beyond all people. Beyond all people in the world."

Inwardly, the writers referred to in the article were insightful beyond the realm in which most non-addicted mortals write. Paradoxically, they unwittingly discovered a world which has a one-way ticket and this motivated tragically magnificent exposés of their pent-up souls. They were fictional explorers of man's existentialism.

Doug Hockley
Vancouver
British Columbia



Old writs still used

It is important to correct a point made by Pat Ohlendorf in her article on the writs of assistance, We may see '1984' soon, says NDP, (**The Journal**, Dec 1981). The author erroneously indicated the writs have not been used since 1976. There has not been a cessation in the use of the writs. Rather, the federal government stopped applying for any *new* writs of assistance. The existing writs that had previously been issued to RCMP (Royal Canadian Mounted Police) drug officers have continued to be used.

This moratorium on applications was imposed following Mr Justice Collier's criticism of the extraordinary powers granted in the writs. Following Mr Justice Collier's comments, Mr Basford, then Canada's minister of justice, indicated tighter legislative controls would be imposed on the writs. The Federal Law Reform Commission of Canada is currently examining the entire question of the writs. As yet, no legislative controls have been introduced. It would appear the Solicitor-General is attempting to lift the moratorium, without waiting for the Law Reform Commission's Report or introducing legislative controls.

Robert Solomon
Associate Professor
Faculty of Law
University of Western Ontario
London, Ont

TJ excellent and helpful

This department would like to congratulate you and your personnel on an excellent and interesting publication which we find to be both stimulating and helpful.

Director-General
Department of Health, Welfare and Pensions
Pretoria
Republic of South Africa

British scene is chaotic

I endorse Alan Massam's report (**The Journal**, Nov) that the alcohol scene in the United Kingdom is one of chaos. However, from first hand reports we know that, far from diminishing, the role of Alcoholics Anonymous is growing fast in this unfortunate country.

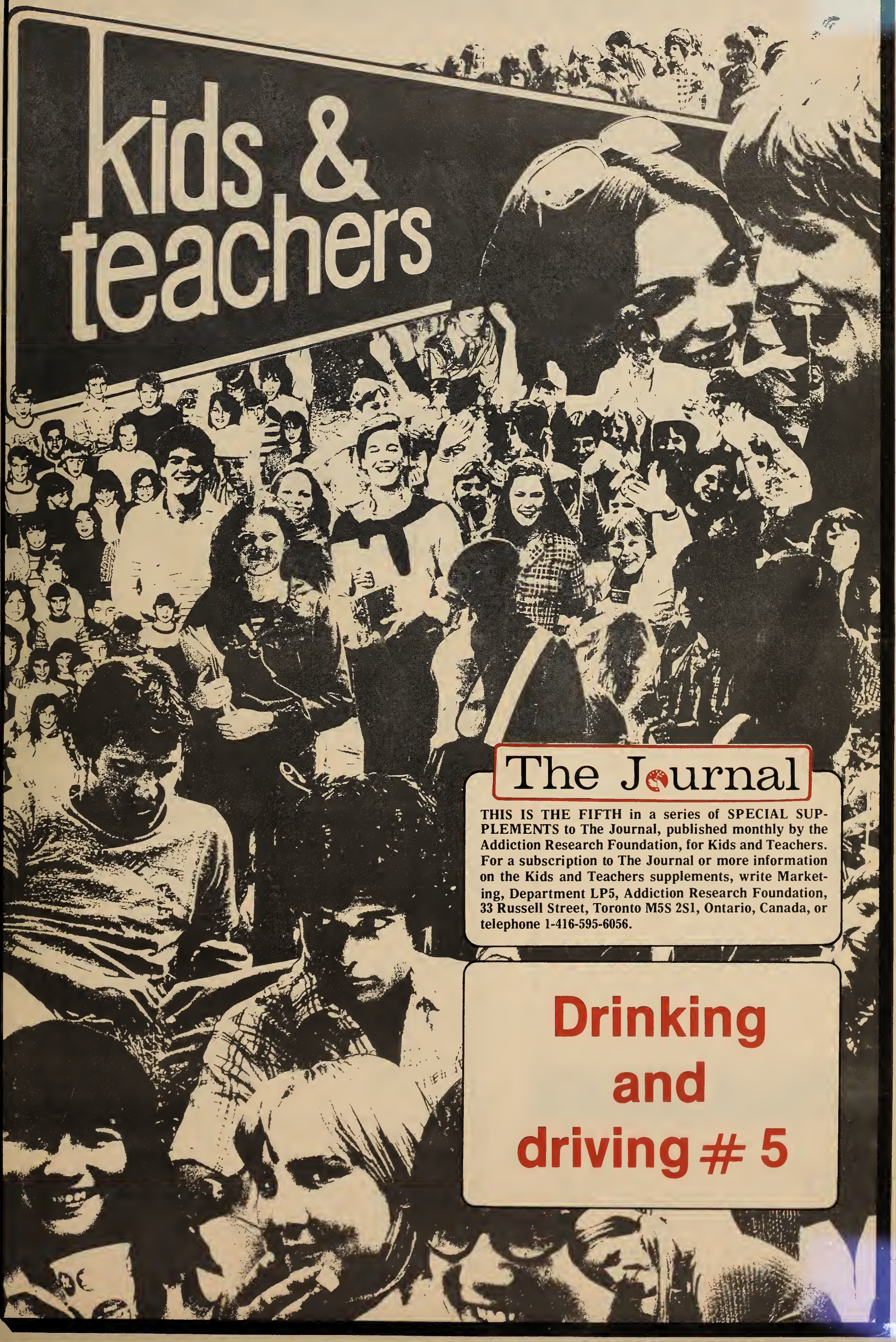
There is confusion in the alcoholism field here because there is no firm leadership from either government or voluntary organizations. Since giving evidence to the Short sub-committee in the House of Commons in December, 1976, about the ignorance of the effects of alcohol among professionals here in the UK, as well as bringing evidence of FAS (fetal alcohol syndrome) to that committee, we at All Faiths' World Alcohol Project continue to struggle on in what one might see as a hostile environment.

We work to inform the medical profession here of the effects of alcohol on its unsuspecting users. In particular, we point out that FAS is preventable and that alcoholism is a treatable condition. We are opposed to the treatment approach which suggests alcoholics can be taught to drink in moderation.

Ronald Forbes
Hon Executive Director
ALFAWAP Trust Fund Limited
London, England

The Journal welcomes Letters to the Editor. Please send your letters to The Editor, **The Journal**, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

kids & teachers



The Journal

THIS IS THE FIFTH in a series of SPECIAL SUPPLEMENTS to The Journal, published monthly by the Addiction Research Foundation, for Kids and Teachers. For a subscription to The Journal or more information on the Kids and Teachers supplements, write Marketing, Department LP5, Addiction Research Foundation, 33 Russell Street, Toronto M5S 2S1, Ontario, Canada, or telephone 1-416-595-6056.

Drinking and driving # 5

kids & teachers

YOU ASKED US . . .

Dear Karen,
With ski season in full swing, I'd like to ask you a question. When my friends ski, they always take a wineskin along. They say drinking keeps you warm. I saw a cold water survival program on TV that said this isn't true. Who's right? **— Cold Feet**

Dear Cold Feet,
It's clear that drinking actually *decreases* body temperature. Your body will get *colder* while drinking and exercising, not warmer. Here's what *Alcohol and Waterfront Recreation*, an information review produced by the Addiction Research Foundation (1981), has to say:
"Physical activity — on land or water — results in an increase in glucose (blood sugar) levels in the body. This glucose serves as a fuel supply to the muscles, and is required to produce heat during active exercise. The presence of alcohol interferes with glucose production by the liver. If alcohol is combined with strenuous exercise, the blood glucose level may fall (hypoglycemia), and this can lead to confusion, weakness, and an upset in body-regulating mechanisms. Shivering — a reflex, heat-producing action of the muscles — is impaired by alcohol. Alcohol causes blood vessels in the skin to dilate (expand), so that more heat can be lost from the blood to the outside environment."

Apart from the issues of impairment while skiing, and drinking in unlicensed areas, drinking and skiing could result in a dangerous drop in body temperature (hypothermia). Hypothermia can be fatal.

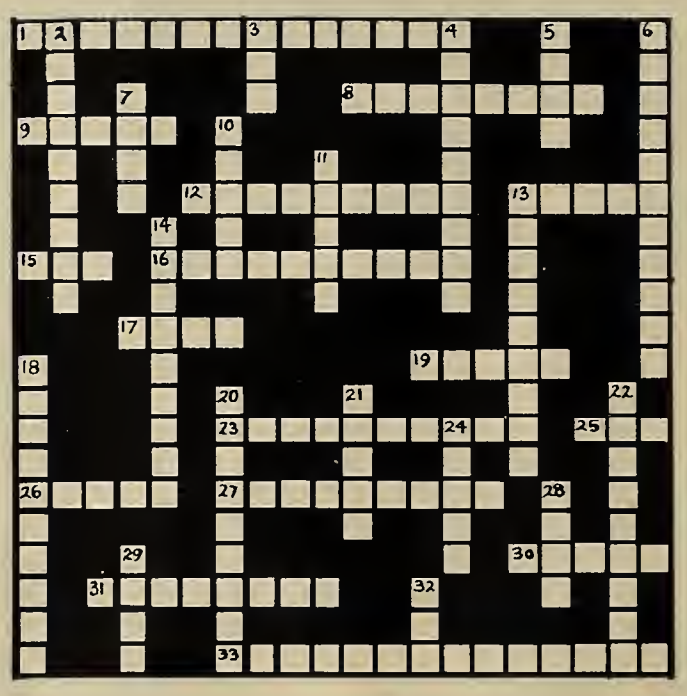
Dear Karen,
I had my first hangover last month. I felt really rotten for about six hours after I woke up. I tried taking aspirin and having a hot bath. Nothing seemed to help. My sister said if I'd had coffee before I went to bed, I wouldn't have had the hangover. My dad said that a raw egg in orange juice would do the same thing. What's the story here?
— Headache

Dear Headache,
I'll explain two things — sobering up and hangovers.

There's no doubt about it — the only way to sober up is time. No amount of coffee, cold showers, exercise, or eating will sober you up. You require 1.4 to 1.9 hours for each drink consumed to eliminate alcohol completely from your body. A standard drink equals 12 oz beer, 1½ oz liquor, 5 oz table wine, or 7½ oz malt liquor/beer.

Secondly, drinking heavily over a short period of time may produce a hangover (headache, nausea, shakiness, and possibly vomiting) beginning eight to 12 hours later. A hangover is the body's reaction to too much alcohol. It is partly related to alcohol poisoning and partly the body's response to withdrawal from alcohol. There's no way to prevent a hangover if you've been drinking heavily over a short period of time. You can only treat the symptoms. Again, only time will cure a hangover.

Is there something you want to know about drugs? Karen Girling answers a lot of questions from students and teachers in her job as information specialist at the Addiction Research Foundation. Why not ask her? Write Karen, c/o *Kids and Teachers*, The Journal, Addiction Research Foundation, 33 Russell St., Toronto, M5S 2S1 Ontario, Canada. Names will be withheld.



CROSS WORD

Across
1. It's dangerous to operate any vehicles after taking these drugs (14)
8. Some people drink at parties to feel more _____ (8)
9. Frightening (5)
12. Heavy drinkers can suffer memory loss and may often be _____ (9)
13. If you were not at the scene of a crime and can prove it, you have an _____ (5)
15. Your liver can burn up about three-quarters of a drink in _____ hour (3)
16. The marijuana user's perception of time and space undergo _____ (10)
17. Drinking before driving greatly increases the _____ of a serious accident (4)
19. An accident is hard to _____ if your reactions are slowed by alcohol (5)
23. Some people want to gain _____ by their peers and hope that drinking with the crowd will help (10)
25. Avoid riding in a _____ with an intoxicated driver (3)
26. The same amount of alcohol is more concentrated when it reaches the _____ in a smaller person (5)
27. If you have an alcohol-related accident, your _____ rates will likely increase (9)
30. More than _____ percent of drivers killed in vehicle accidents had been drinking (5)
31. Marijuana alters a person's perception of _____ (8)
33. Hay fever relievers that combine with alcohol to make driving more than doubly dangerous (plural) (14)

Down
2. These are much quicker if you don't drink (9)
3. To drive with a blood alcohol level of 0.08% or greater is against the _____ (3)
4. Opposite of depressant (9)
5. If it isn't too far, you can refuse a ride with an intoxicated person and _____ home (4)
6. These may disappear as you drink more (11)
7. It is _____ that alcohol has a greater effect on women than on men of equal weight (4)
10. Food in the stomach initially _____ down absorption of alcohol into the bloodstream (5)
11. These may flow more easily if you're feeling sad when you drink (5)
13. Person whose insurance rates are lower than those of someone who drinks (9)
14. Heavy use of heroin leads to _____ (9)
18. What our livers do with alcohol (10)
20. It's risky to smoke this drug before driving any vehicle (9)
21. Some people worry that not drinking may set them _____ from their friends (5)
22. A quiet person may become more _____ when drinking (9)
24. Rhymes with slicer (5)
28. After several drinks, you might _____ on an icy surface and injure yourself (4)
29. People who have been drinking for a long _____ usually know what effect certain amounts and types of alcohol will have on them (4)
32. The carbon monoxide produced by lit cigarettes is a poisonous _____ (3)

Across
1. TRANQUILLIZERS, 8. SOCIABLE, 9. SCARY, 12. FORGETFUL, 13. ALIBI, 15. ONE, 16. DISTORTION, 17. RISK, 19. AVOID, 23. ACCEPTANCE, 25. CAR, 26. BRAIN, 27. INSURANCE, 30. FIFTY, 31. DISTANCE, 33. ANTIHISTAMINES.

Down
2. REACTIONS, 3. LAW, 4. STIMULANT, 5. WALK, 6. INHIBITIONS, 7. TRUE, 10. SLOWS, 11. TEARS, 13. ABSTAINER, 14. ADDICTION, 18. METABOLIZE, 20. MARIJUANA, 21. APART, 22. TALKATIVE, 24. NICER, 28. SLIP, 29. TIME, 32. GAS.

1. OPTIONS
2. KNOWLEDGE
3. VALUES
4. CONSEQUENCES
5. DECISION
6. EVALUATION

Everything had gone fine until after lunch. Then the vice-principal brought Bill in for questioning. Bill had seen the custodian removing his lock.

At first he thought they'd never think to look in the gym bag. But damn, everything collapsed so fast. He'd been suspended and a letter sent to his parents.

With quick thinking, he still might be able to intercept that letter! It would save his parents and him a lot of grief. Besides, if his dad thought back to when he was young, he'd remember doing some dumb things, too. It was all part of growing up.

He'd pretend to go to school, then sneak home and get that letter. Might even have a drink when he was there. Lord knows, he'd earned it.

Stupid rules. All because society wouldn't let people be themselves and make up their own minds about issues.

* * *

(1) If Bill's sister, Jessica, were to see him take the letter, what should she do? Use the decision making model (see the first issue of **Kids and Teachers**) summarized above to outline Jessica's choices.
(2) Write a few lines from the conversation between Bill and the vice-principal.

THE KIDS ON HIGH ST.

featuring Al Ked

. . . WE ASKED YOU

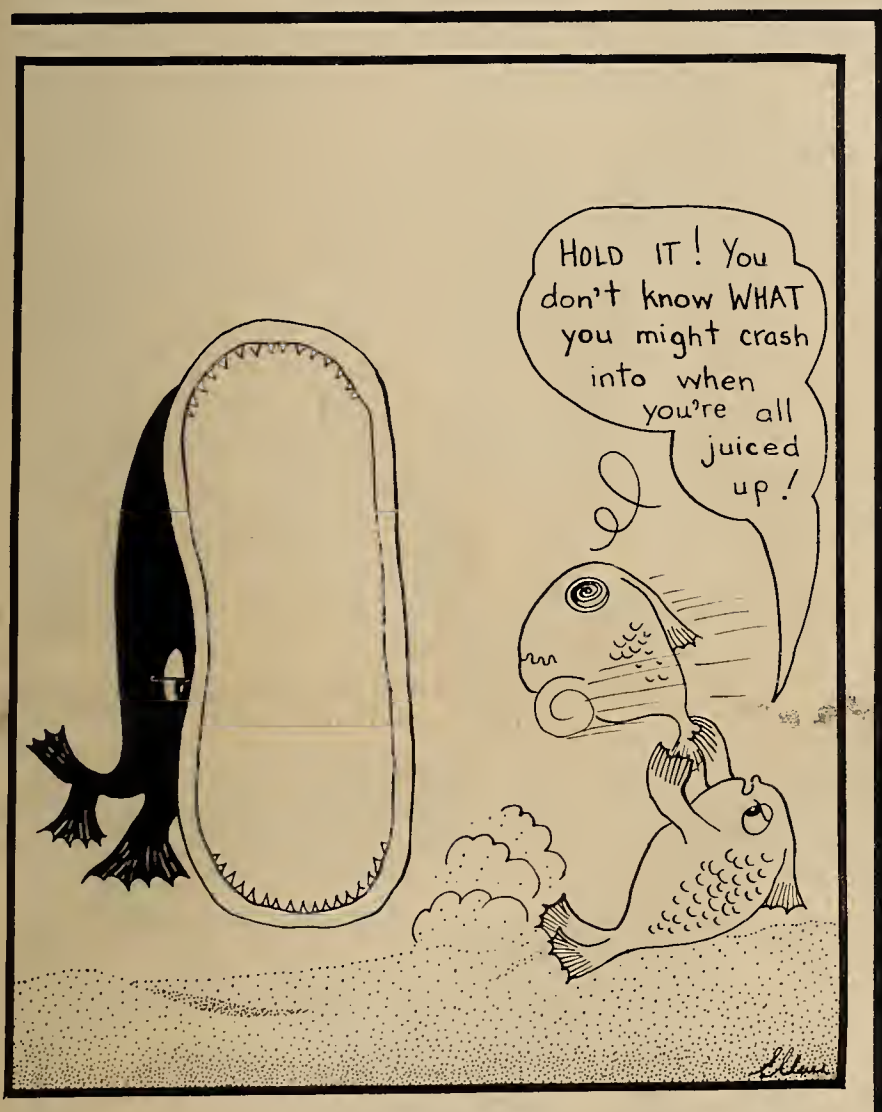
kids & teachers

What factors in the driver's behavior and appearance would you consider in deciding whether to accept a ride home from a party with someone who may have been drinking? How would you check this out? Would it make a difference if the person is a friend?

Mary and Brent will be asking other teenagers questions each month for Kids and Teachers. If you have a question you'd like Mary and Brent to ask, send it to them at: Kids and Teachers, c/o The Journal, 33 Russell St, Toronto M5S 2S1, Ontario.

Shawn, 18:

There are certain characteristics of a person too impaired by alcohol to carry out tasks such as driving. If I was offered a ride home from a party by a person who was staggering, slurring their speech, and exhibiting loss of motor control (eg burning themselves with a cigarette), I would seriously consider not accepting a drive or even getting in the same car with this person. If it were a friend, I might accept a ride home even if they were drunk. Some of my friends drive perfectly well wacked right out of their gourds.



John, 18:

It depends on whether you've been with them that evening, so you can tell. People can and do put on acts. I'd probably try to talk a friend out of driving, but the problem is that you often *need* a drive home so you're forced to use them for a ride, regardless.

Kathryn, 20:

I'd watch his eyes, timing, and reactions. I'd talk to him to find out how he reacts in conversation. If it was a friend who was bombed, I wouldn't go with her/him.

Liz, 18:

I don't care who they are or what kind of friend they are, I wouldn't get in the car with anyone who has been drinking, even if I only have a suspicion from their behavior or physical appearance. It's not worth the risk. I don't have a death wish.

Russell, 16:

I'd like to check that they're walking all right and responding to conversation normally. I would also think about where we are going, for example on a highway or side street; and the amount of traffic that we'd be involved with. The main thing would be who it is. It would definitely make a difference if you knew who they were, since you would know how good a driver they are normally. If they are just "buzzed-out" it's okay but if they're "loaded," no way.

Jane, 15:

I'd check their appearance; if it was below normal. I'd check their behavior; whether they were making fools of themselves. I'd ask them if they feel they're able to drive home safely. I'd also consider how long the driver had had his or her licence. If the car had loads of people in it, I'd decline. It would make a difference if they were a friend because they would give a more straightforward answer when asked if they can drive safely. They'd be more concerned with taking my life into their hands.

Cathy, 16:

I'd make sure the person didn't have slurred speech. I'd check out whether they look tired, or have red eyes, how aware they are about what's going on around them, and if they can walk straight. I think it would make a difference if the person was a friend. People tend to be more lenient and trusting with friends. If they're friends you can check to see if they're acting like themselves.

Warren, 18:

I would watch their walking and whether they stand and hold themselves awkwardly. If they had extremely slurred, or erratic speech and used more hand gestures than usual, it could indicate intoxication. If the person was a friend I would have a better idea of his limits and capabilities. Basically I'd have a better knowledge of how drunk he is.

Are you enjoying **Kids and Teachers**? Let us know. Write us c/o **The Journal**, 33 Russell Street, Toronto, Ontario M5S 2S1.

ASK YOURSELF

Test Your Drinking and Driving IQ

1. What percentage of Ontario's 1980 driver-fatal traffic accidents were alcohol-related?
   a) over 20%
   b) over 30%
   c) over 40%
   d) over 50%
   e) over 60%

2. To help you sober up before driving you need:
   a) coffee
   b) a cold shower
   c) food
   d) exercise
   e) time

3. The amount of alcohol in one 12 oz bottle of beer equals the alcohol in:
   a) 5 oz table wine
   b) 24 oz the lightest beers
   c) 1½ oz spirits
   d) 7½ oz malt liquor/beer
   e) all of the above

4. How many hours *per drink* should you allow before driving, according to a popular rule of thumb?
   a) ½ hour
   b) 1 hour
   c) 2 hours
   d) 3 hours
   e) 4 hours

5. What is the major component in driving that is most affected by alcohol intoxication?
   a) finger dexterity
   b) color discrimination
   c) ability to process the various activities involved in driving
   d) ability to hear high-pitched sounds
   e) none of the above

6. Which one of the following five individuals could drink the same amount over the same period of time as the others, but might have a lower blood alcohol level and be less impaired?
   a) tall, lean, 140 lb female taking cold remedies
   b) tall, lean, 190 lb male aged 30
   c) short, lean 105 lb female alternating coffee with her drinks
   d) overweight female of average height with diseased liver
   e) tall, underweight, 135 lb male with healthy liver

7. It is possible for a person to be impaired, yet still remain under the legal blood alcohol level if he or she is:
   a) combining alcohol with medications such as antihistamines, sleeping pills, tranquillizers, and antidepressants
   b) inexperienced with drinking and driving
   c) anxious, frustrated, depressed, or tired
   d) all of the above
   e) none of the above

8. How can a host or hostess reduce the possibility of guests leaving a party in an impaired state?
   a) provide food early on and throughout the party
   b) provide alternatives to alcoholic beverages
   c) provide backup transportation home
   d) follow the one-drink-per-hour rule
   e) all of the above

Check your answers below.
1. d) 2. e) 3. e) 4. b) 5. c) 6. b) 7. d) 8. e)
How many questions did you answer correctly?
8 correct — WOW!
6-7 correct — good
3-5 correct — not too bad
0-2 correct — hmm . . . maybe you'd better try again

kids & teachers

Drinking and driving

Teacher Objective
To help students understand why people should not drive after drinking alcohol or taking other drugs.

Student Objective
To understand that operating any vehicle or equipment requires skills that can be impaired by alcohol and other drugs, and that alternatives are available.

Step 1
Make a collage, an overhead transparency, or a chart to show students a variety of drinking-driving safety slogans, such as:
Don't drink and drive
Make your one for the road coffee
Stay alert, stay alive
No thanks, I'm driving

Ask: **Why is there so much concern about drinking and driving?**

It is dangerous to drink and drive. We know that at least 50% of all drivers killed in vehicle accidents (ie automobiles, snowmobiles, motor boats, motorcycles) had been drinking. Drinking is also a factor in many non-fatal accidents. You are three to four times more likely to have an accident after drinking than before.

Ask: **Why is it so dangerous?**

Alcohol depresses parts of the brain. This affects judgment, so people may think they are capable of driving when they really aren't. Coordination and reflexes are also affected by alcohol, and people cannot react as quickly as they normally would. Although split seconds may not seem like much, they can mean the difference between a "close call," minor damage, personal injury, and death. For those who have had quite a bit to drink, vision becomes blurred; they may not notice a pedestrian entering a crosswalk until it's too late.

Ask: **What does impaired driving mean?**

Legally a person is intoxicated when the blood alcohol level is 0.08% or higher. However, studies have shown that many people cannot properly handle a vehicle even at lower blood alcohol levels. Their driving ability is impaired.

Step 2
Ask: **How many drinks does it take to make someone an impaired driver?**

The alcohol wheel is a handy guide to impairment levels. (Follow instructions on wheel B to assemble it.) It computes the blood alcohol level using a person's weight, the number of drinks, and the timespan over which the drinks were taken. Since the wheel is geared to men, women will have a slightly higher actual blood alcohol level than indicated.

Once you've assembled it, try it. Suppose you've had three average drinks in two hours and calculate your blood level.

Experiment with other combinations: What would your blood alcohol level be if you weighed 20 kilos more? What would it be if you had two drinks in two hours? etc

Ask: **What can people do to make sure they are not impaired when they drive or operate machinery?**

Wait at least one hour per drink before operating a car, snowmobile, motorcycle, dirt bike, motor boat, bicycle etc.

Have no more than three-quarters of a drink an hour.

Better yet, don't drink if you have to drive or operate machinery.

Step 3
In We Asked You (Kids and Teachers, #2), the teenagers said they would not accept a ride with an impaired driver. What other choices do you have in such a situation?
Brainstorm a list of options.

Step 4
Set up the following role-playing situation by asking for three volunteers. Do not tell the class what the situation will be. Give each volunteer a piece of paper with his or her instructions printed on it.
Student 1:
You have been babysitting for several hours on Friday night. It is now after midnight and you are expecting the parents home soon.
Student 2:
You are the father of two young children. You've been at a party with your wife and have been drinking rather heavily. You've just arrived home in a taxi and wish to drive the babysitter home.
Student 3:
You are the mother of two young children, and have been enjoying drinking lightly at the party you've just been to. Your babysitter will need a ride home, but you know that your husband has been drinking rather heavily.

Have the students play the roles. Discuss the role-playing situation. What safe choices does each person have?

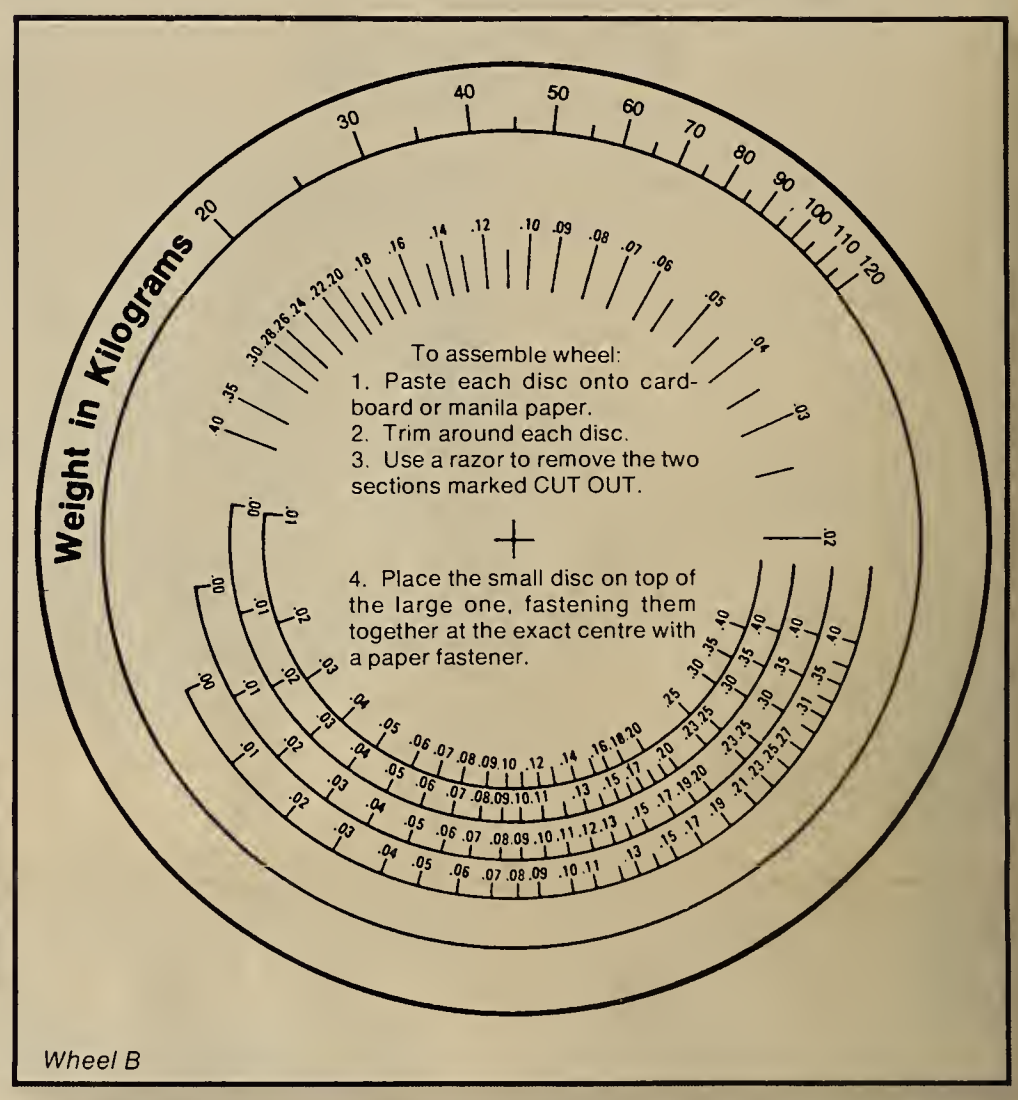
Step 5
The main concern about impaired driving centres on alcohol, yet other drugs can also impair ability to drive a vehicle. Can you name a few and tell why?

Marijuana	— slows reaction time; distorts time and distance perception
Tranquillizers	— depress body functions and slow reaction time, like alcohol
Antihistamines	— depress body functions and slow reaction time, like alcohol

Ask students to research on their own which over-the-counter drugs bear the warning "Do not drive or operate machinery while taking this drug." Make a class list of such drugs.

Step 6
Some student projects:
1) Investigate abstainers' insurance rates and compare them with regular insurance rates and with rates for young male drivers
2) Investigate how insurance rates are affected a) if you have an accident, and b) if you have an alcohol-related accident
3) Investigate the penalties for drinking and driving offences.
4) Ask your local or school librarian for help in researching accident statistics for drinking and driving.

Ask students to report their findings to the class.



Wheel B

Wheel A

Wheels A and B are reprinted from Finn and Platt, Alcohol and Alcohol Safety. Washington DC: United States Government Printing Office, 1972, and also appear in Finn and O'Gorman, Teaching About Alcohol: Concepts, Method, and Classroom Activities. Boston: Allyn and Bacon, 1981.

Did you know...

The three drinking and driving offences in the Canadian Criminal Code are:
- having control of a motor vehicle, whether it is in motion or not, when your ability to drive is impaired by alcohol
- refusing to take a breath analysis test when a police officer asks you to
- having a blood alcohol level of 0.08% or more when you're in control of a car, whether or not the car is moving.

Editorial team: Anne MacLennan, editor; Greg Arbuthnot, design; Evelyn Cluer, cartoons and crossword; Jerrine Craig, production; Susan Lawrence, editorial consultant; Sharon MacLennan, graphics; Marg Sheppard, education consultant. Columns by Paul C. Brown, Karen Girling, Brent Poulton, and Mary Schankula.

We're always looking for new safety slogans about drinking and driving. Send your own ideas to us at **Kids and Teachers, The Journal**, 33 Russell Street, Toronto, Ontario M5S 2S1.

FEATURES

Jewish culture provides impetus for sobriety: study

By Lynn Payer

NEW YORK, NY — The notion that a Jewish alcoholic is a contradiction in terms — suggested by some to be responsible in part for low rates of alcoholism among Jews — is prominent even in the Old Testament, two Queens College sociologists have found.

John O'Brien and Sheldon Seller also discovered the references to alcohol in the Old Testament are much more negative than in Hellenic literature, previously analyzed by Dr O'Brien (**The Journal**, February, 1981). While 42 positive, and 11 negative categories of reference to alcoholism were found in Hellenic literature, there were 39 positive and 66 negative categories in the Old Testament.

"In Greek literature, we have a fairly clear image of wine as a spiritual staple, the gift of Dionysus, endowed with a wide latitude of beneficial qualities," they said. "In the Jewish scriptures, wine is also a gift from God, even a blessing, but it must be used at the proper time and only in moderation."

Mr Seller called the Old Testament "an encyclopedia of alcohol abuse and alcoholism," with a vast reservoir of quasi-clinical observations including references to a need for abstention during pregnancy (Samson's mother), dependency, increased susceptibility to illness, anxiety, and remorse.

But perhaps most interesting was the finding that, even then, drunkenness and alcoholism were associated with non-Jews. A recent study by Barry Glassner of Syracuse University, (**The Journal,** February, 1981), has suggested that at least part of the explanation of low alcoholism rates among Jews may be their continued assumption that Jews do not drink to excess.

"Throughout the Old Testament, those who drink excessively are non-Jews, or Jews acting as if they were non-Jews," said Mr Seller. "The only drunks are Lot and Noah, who lived before the covenant and therefore were not really Jewish."

"An habitual state of drunkenness signified an atavistic reversal to pagan godlessness and is symbolic of all that is non-Jewish," according to the sociologists. "Not all gentiles are considered drunkards, but drunkenness indicates behavior that reflects failure to accept God, prevents one from leading a spiritual life, and is distinctly non-Jewish."

In Deuteronomy, Mr Seller points out, being a drunk and a wastrel is considered one of the few sanctions for death by stoning.

"It's clear that moderation in drinking was a central point in the way Jewish society defined itself, and a way to distinguish 'The Brotherhood' from 'The Otherhood'," said Dr O'Brien.

"It is significant that we found a reference that said that kings shouldn't drink," he commented. "In other cultures, the priesthood adopts drinking, and then loyalty and identity to the group are reinforced. In Greek culture, drinking was an allegiance test, and it was dangerous *not* to drink. Demetrius was about to be executed for not drinking at the Dionysia and was only saved because soldiers coming to execute him found him drunk as a skunk."

Mr Seller explained that previous explanations of why so few Jews were alcoholic focused on the idea Jews were afraid of the reaction of non-Jewish society if they acted in a drunken manner. "But it looks to us as if the impetus for sobriety came from within Jewish society," he said.

External forces may, however, have been necessary to provide the examples of drunkenness to show Jews what they were not. Problems with alcohol in Israel, he said, have been primarily among Sephardic Jews who, coming from the non-drinking Islamic culture, would not have defined themselves as strongly in terms of their moderation as European Jews might have.

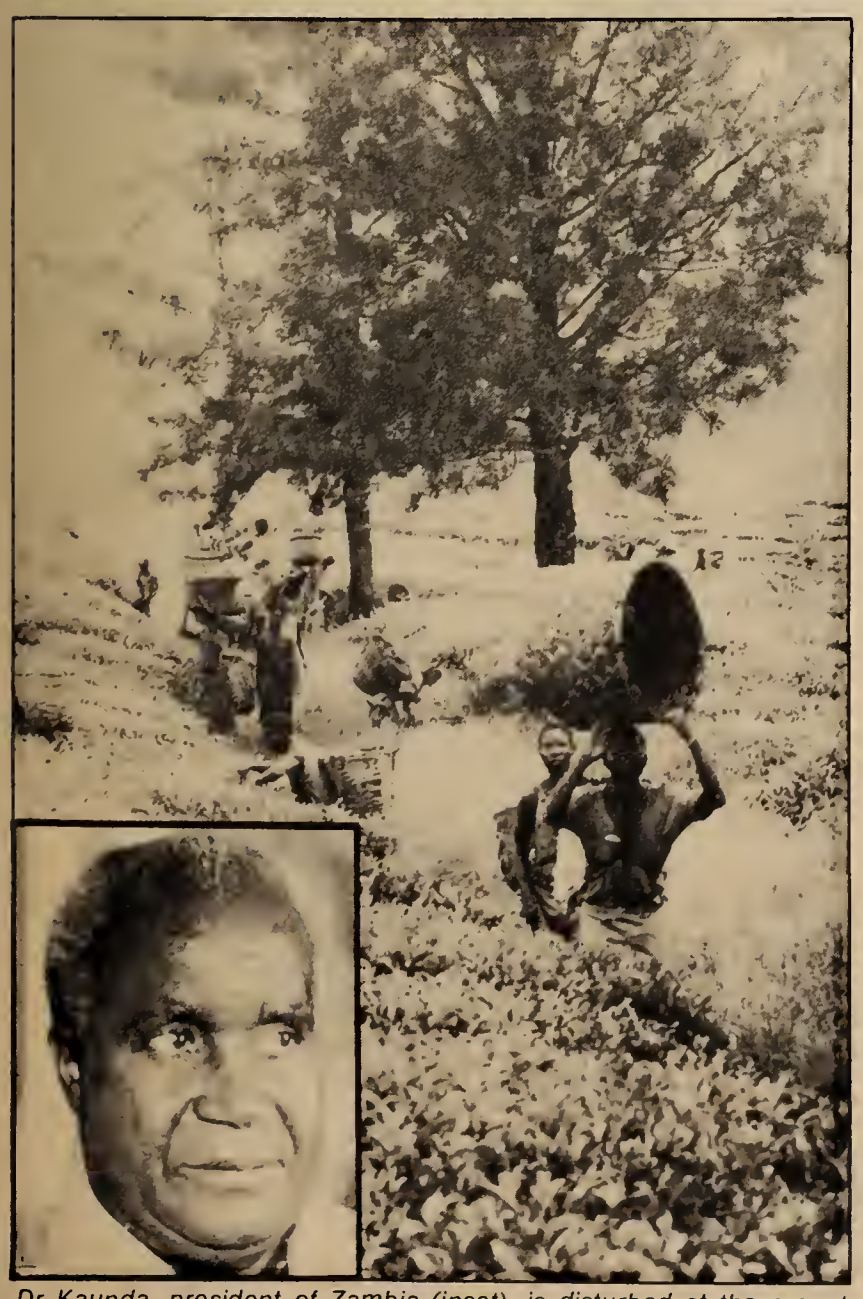
Both Mr Seller and Dr O'Brien admit that such strong feelings that Jews do not drink to excess might have eventually eliminated genes favoring alcoholism from the Jewish gene pool. They nevertheless prefer to emphasize the socio-cultural mechanisms favoring alcoholism and its avoidance.

"If there are genes predisposing toward alcoholism, those genes have the maximum opportunity to be expressed in a culture such as the Irish-American — and a minimum chance in Jewish culture," according to Dr O'Brien.

Their comparison between the Old Testament and Hellenic culture was presented at the International Congress on Drugs and Alcohol in Jerusalem. A chart, which should enable scholars to find all citations relating to alcohol in the sacred books, will be published in *The Drinking and Drug Practices Surveyor*.

Throughout the Old Testament those who drink excessively are non-Jews, say sociologists.

Zambia to probe surge in African alcoholism



Dr Kaunda, president of Zambia (inset), is disturbed at the recent increase in alcoholism in his country. In the past drinking has been restricted to the harvest season.

By Thomas Land

GENEVA — The schools of medicine and humanities and the Institute of African Studies at the University of Zambia in Lusaka have created the first working model for research into alcoholism throughout the continent. It may well be adapted by many other universities, for most African governments are alarmed by a disastrous increase of alcoholism in the wake of social upheavals accompanying the industrial revolution sweeping the region, and they seek corrective action.

The United Nations' World Health Organization (WHO) here, which has assisted the Zambian project, explains: "The evidence of increasing damage in a large number of developing countries suggests alcohol-related problems constitute an important obstacle to their socio-economic development and are likely to overwhelm their health resources unless appropriate measures are taken."

Specialists now talk in terms of "a worldwide epidemic" of alcoholism in both the poor and the rich countries. The developing regions — even including the Islamic World — are particularly exposed.

Alcoholism is a special health risk for vast populations living in conditions of overcrowding, poverty, and squalor. "Excessive drinking," the WHO says, "can have a special impact when nutrition is poor by lowering resistance to disease and increasing mental retardation in cases of high consumption by the mother during pregnancy." It warns that the current era of family breakdowns and widespread migrations by destitute, landless peasants away from the depressed countryside in Africa, Asia, and Latin America to the anonymity of the expanding cities may well exacerbate the problem during the years to come.

Hence the significance of a global research program initiated by the WHO in collaboration with universities in Zambia, Mexico, and elsewhere.

Dr Kenneth Kaunda, the teetotaller Zambian president, has been disturbed by the spread of alcoholism in his country for years. But his administration has been unable to formulate effective prevention, control, and treatment programs in the absence of adequate research data. A set of reports has now been published concluding the initial phase of the study. Professor Muyunda Mwanalushi, the former dean of humanities at the University of Zambia, expects them to lead to rapid reforms at home and to a spate of related investigations in other African countries using the model developed by his university.

Beer is traditionally consumed in Zambian society, but drunkenness used to be infrequent. Drinking had a place in ceremonial occasions as an offering to ancestral and other spirits. The availability of drinks was restricted to the harvest periods and the alcohol content of beer was relatively low.

Urban pressures have now created a figure unknown in traditional African society — the lonely drinker seeking to get drunk.

Statistics assembled by the Zambian investigators show heavy drinkers are getting younger and more violent at a rapidly escalating cost borne by society. Alcohol is thus accepted as a significant contributory factory in 24% of all cases brought before the courts and in more than half of all road accidents.

The problem is so acute in the region that the government of neighboring Zimbabwe has just been forced to order the closure of thousands of drinking establishments in an effort to cut crime.

Professor Mwanalushi, co-principal investigator, with Dr Alan Haworth, on Phase One of the WHO Community Response to Alcohol Problems Project in Zambia, proposes a set of immediate reforms. They are likely to be considered as a matter of urgency throughout the region.

They include establishment of a legally constituted commission on alcoholism and alcohol abuse to undertake continuing research and to provide advice to government departments and other concerned organizations in a broad context of national development.

Significantly, the research workers urge social planners to recognize the reliance of governments on the alcohol industry for raising tax revenues, and its indirect effect encouraging alcoholism. They also seek increased restrictions on the availability of drinks, particularly for young people, and the promotion of alternative activities as well as education.

INTERNATIONAL

UK soldiers sober up with education

By Alan Massam

LONDON — The modern British soldier is more intelligent and better adjusted socially than his counterpart in civilian life. Moreover, if he has an alcohol problem he is exposed to a carefully-evolved regimen of treatment and rehabilitation.

For the modern army has no room for heavy drinkers who could cause costly accidents. Yet it avoids discharging the expensively-trained soldier if possible.

The new approach was described here recently by Brigadier P.D. Wickenden, director of army psychiatry, ministry of defence. He told the British Medical Council on Alcoholism that until 1973 army medical services adopted a passive posture toward the treatment of alcoholism

At that time, all service patients tended to be in their late 30s, truly addicted, and suffering from some degree of irreversible damage. Treatment involved a good three months of in-patient, Alcoholics Anonymous-style group therapy.

Brigadier Wickenden gave much credit for the change in the army's approach to alcoholism to Dr Paul Gwinner, an army psychiatrist who, in 1973, evolved an education program to influence the young drinker, and a treatment program aimed at rehabilitation rather than discharge.

The word was spread that the rate of chronic alcoholism was directly related to drinking habits in the community and curbs (with heavier punishments) advocated. "It is easy enough for a commanding officer to identify the heavy drinkers in his unit, it is only a question of opening the blind eye," he added.

Once the drinker was identified it was the duty of his officer to make the first approach and warn him (or her) of the likely consequences. If this approach was unsuccessful the drinker would be referred to the army medical service.

A medical officer might then refer the patient to a psychiatrist and then for out-patient therapy or admission to an alcoholism treatment unit. Here he or she would get withdrawal, assessment, and a program of education, group discussion, and demonstration. Finally, the soldier might be returned to duty, given further therapy, or discharged. In the most favorable cases, follow-up might be as short as six months, but generally it was maintained for as long as possible.

The brigadier said 70% of soldiers receiving treatment are now under 30 years of age, with privates and junior non-commissioned officers being over-represented.

Twice as many alcohol abusers are being seen now as compared to 10 years ago, but this is because they are being actively sought. Admission rates are steady and medical discharges for alcoholism have been declining over the last three years.

"Measures to control alcoholism rely more on education than on restricting the supply and availability of alcohol," he declared.

Alcoholics' families need help

LONDON — An essential feature of treatment in a comprehensive alcoholism program is the involvement of the family of the patient; the objective should be to help family members identify their own attitudes to the patient and the problems.

This was given special emphasis by Daniel J. Anderson at the World Conference on Alcoholism here.

Dr Anderson, director and president of the Hazelden Foundation, Center City, Minnesota, told the conference the rationale for treating family members was clear. While the patient in treatment is learning a new way of life — a new way of coping with life without alcohol — someone should be helping family members modify their stereotyped, repetitive, and maladaptive responses to the alcoholic's behavior.

The problem is not the primary illness, but the response to the primary illness. Thus one of the goals of family intervention is to help stop other family members repeating pathological responses which they made when the alcoholic was ill.

Typically, the family, peers, and friends fail to admit the symptoms of alcoholism are present and have been for some time. They tend to deny the illness concept and believe that if only they could learn a magic formula, they could learn to control the alcoholic's behavior.

At the same time, however, they reject the alcoholic for displaying that behavior. Just as the alcoholic rationalizes and makes excuses for drinking, so the family and friends make excuses for the abnormal drinking, rather than accepting that the person needs treatment. Dr Anderson said family programs must be geared to help family members to identify their own "attitudinal problems." Thus they would be able to modify their reactive behavior where necessary and know what to expect when the patient returns.

Family programs also teach "significant" family members how to stop centering their lives around the alcoholic, and how to detach themselves from the alcoholism while still loving the person.

The programs are generally short-term and might be inpatient or outpatient in structure. They might consist of orientation sessions to acquaint the family members with the program, followed by educational lectures, and group therapy sessions to allow sharing of experiences with members of other families.

Drug leaks

NEW DELHI — Leakage of narcotic drugs generally takes place at the hospital ward level, says a report on the Indian Pharmacists Training Course.

The report points out there is little or no control over the storage of psychotropic substances, particularly tranquillizers, and urges greater supervision of drugs issued by hospital stores.

INTERNATIONAL

Third World cigarettes are under investigation...

By Jim Magee

GENEVA — At a market stall in the bustling streets of an African city, a man in shirt-sleeves buys two packages of cigarettes from the trader, stepping over piles of old magazines and second-hand shoes to the pavement.

In a brightly-lighted shopping centre in a city in South America, a woman casually buys a pack of a well-known, international brand of cigarettes.

In fact, the purchases are not as casual as they appear; they are part of an international survey now being conducted under sponsorship of the World Health Organization (WHO) in Geneva.

"We are testing cigarettes on every continent," Roberto Masironi of WHO told **The Journal**.

"About 50 brands are involved in this first operation, including both locally-made and imported cigarettes, and the objective is to obtain some reliable scientific data about the levels of tar, nicotine, and carbon monoxide."

WHO's collaborating centre is the Addiction Research Foundation in Toronto, which has contracted to carry out necessary analyses. The aim is to find out whether it is true cigarettes being sold in developing countries have a higher content of such substances than those on the market in the richer countries.

"Why the tobacco industry would want to sell cigarettes with these higher levels in developing countries is a matter for speculation," Dr Masironi said. "If they are doing so, it might be for one of three reasons — one, deliberately to keep smokers hooked by giving them more nicotine, for instance; two, it might simply be cheaper to produce high level cigarettes; or three, it might be that they are dumping stocks they can no longer sell in the developed countries because of stricter legislation."

Dr Masironi emphasized it is not the aim to produce a WHO standard for cigarettes. That is a matter that lies within the powers of the national governments.

"All we are concerned about at present is to see if there is any foundation for the allegations that have been made in this regard."

In this connection, Dr Masironi said there is already indirect evidence that there is an important health benefit in controlling the levels of toxic substances

"In the three countries where levels are lowest, the United States, the United Kingdom, and Sweden, there has been a marked decline in cardiovascular illness and cardiovascular-linked mortality."

"In the view of WHO, there should be pressure in all countries to continue to lower these levels of tar, nicotine, and carbon monoxide. At present, in the US cigarette, there is probably only half as much tar and nicotine as in the cigarette on sale in developing countries.

"We are going to keep pressing for continuous reduction," he said.

...ARF smoking machine will give results

TORONTO — Scientists at the Addiction Research Foundation of Ontario (ARF) are using "standard methods based on those used by the United States Federal Trade Commission" to test cigarettes for the World Health Organization (WHO), says pharmacologist Rick Frecker, head of the project. The tar, nicotine, and carbon monoxide contents of many cigarette brands from developing countries around the world are being tested by smoking machines.

Dr Frecker, who has "a scientific interest in the process of acquisition of the tobacco habit in the developing countries," estimates the analyses will take about a year to complete.

Results should be on their way to the WHO by late 1982.

NEWS

'Alcoholism gene' eluding scientists

BOULDER, CO — Despite tantalizing suggestions that alcoholism is inherited, a review of the literature concludes studies on the genetics of alcoholism lack one important ingredient: they have been unable to explain the mechanism through which the "alcoholism" gene is expressed.

That's the conclusion reached by Richard A. Deitrich of the University of Colorado School of Medicine, Denver, and Gerald E. McClearn of the Institute of Behavioral Genetics, University of Colorado, Boulder. Their review of the genetic basis of alcohol susceptibility was reported at a symposium here on the Neurobiological Correlates of Intoxication and Physical Dependence upon Ethanol.

Most scientists studying the problem have derived their information from studies of family resemblance, comparisons of twins, and examinations of the resemblance of adopted children to their biological and adoptive parents. All three types of studies suffer, however, from certain assumptions which must be made but which may not be true, they said.

In family resemblance studies, one may assume family resemblances are the result of genetic factors. The fact is, a similar environment might be the cause. And it is most likely both genetic background and environment are involved.

In twin studies, scientists compare identical twins with fraternal twins. Identical twins develop from the same fertilized egg and so are genetically identical. Fraternal twins develop from two different fertilized eggs and are no closer genetically than ordinary siblings. Researchers make the assumption that a greater resemblance in behaviors between identical than between fraternal twins is the result of shared genes.

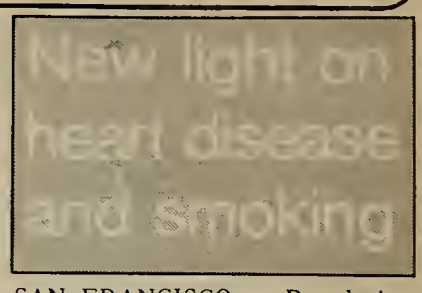
When scientists study adopted children and their parents, they assume that greater similarities between the children and their biological parents than between the children and their adoptive parents are the result of genetic effects. Of the three types of studies, properly controlled adoption studies provide the most conclusive evidence for the genetic basis of a behavior.

Drs Deitrich and McClearn said all three types of human genetic studies have provided evidence of a genetic influence on alcohol consumption. And, the caveats notwithstanding, that evidence looks good.

So what is different about the genetics of alcoholics or potential alcohol abusers? What genetically controlled factor, or factors, do these people have?

Scientists don't know, say the Colorado investigators. Several suggestions have been made, including a difference in alcohol-metabolizing enzymes in sensitive people, a chemically mediated alcohol preference, and differences in central nervous system effects. Many alcohol-related bevaviors are known to be inherited in animals.

In their concluding remarks, Drs Deitrich and McClearn said: "Evidence is accumulating that genes influence the probability that a person will be diagnosed as an alcoholic." This does not mean, the investigators were careful to note, that environment plays no role. But a large part of the variance in alcohol susceptibility is probably due to genetic differences.



SAN FRANCISCO — Population studies have long linked cigarette smoking to heart disease, but scientists have been baffled about how tobacco smoke causes its damage.

Now scientists at the University of California, Los Angeles, have shed new light on the mechanism by which cigarette smoke may lead to atherosclerosis.

Blood vessels of animals exposed to cigarette smoke show extensive damage when examined under the scanning electron microscope, George F. Sieffert reported at the 67th annual Clinical Congress of the American College of Surgeons here.

"The results of our study demonstrate that major endothelial damage occurs with tobacco smoke inhalation, and may have a causal relationship to the development of atherosclerosis," Dr Sieffert said.

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ISSN 0044-6203 Printed in Canada

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Susan Reid, the coordinator of the group, at (416) 595-6150.

Health Wreckers

Number: 479
Subject heading: Drugs and youth; smoking; youth and alcohol; attitudes and values; archival.
Details: 13 min; 16mm; color.
Synopsis: The message in this film is that alcohol, drugs, and cigarettes can be harmful to a person's health or, in other words — "health wreckers." The film suggests that if people are "mature enough to make a decision about drinking," then they "won't drink too much." Other drugs can be helpful in treating medical problems but their non-medical use can be detrimental to health. The cigarette smoker "almost becomes a slave to his health wrecking behavior," and "each cigarette is a tiny step toward a health problem." The film concludes with the message "good health is an important part of life," and "a person can enjoy life without too much alcohol, without abusing drugs, and without polluting his lungs with cigarettes."
General evaluation: Poor. The A/V Group felt the film was poorly produced in that many of the segments were merely sequences taken from earlier films (eg feeding fish alcohol). The group did not like the distinction made between "alcohol" and "drugs," which they felt suggested that alcohol was not a drug. Generally, the film was judged to be boring, unrealistic, and outdated. Despite the appropriateness of the film's length is was judged to be an ineffective teaching aid.
Recommended use: The film is appropriate for children between the ages of eight and 11 years and was judged to be neither harmful nor beneficial to all audiences.

Narcotics File: The Taming Of A Flower

Number: 480
Subject heading: Drug use: history; etiology and epidemiology; drugs — pharmacology.
Details: 27 min; 16mm; color.
Synopsis: The use of morphine and its derivatives to help ease the pain of patients under medical supervision is widespread. This film speaks of the cultivation and harvest of the opium plant, which is essential for manufacturing morphine. The film also emphasizes the lifestyle surrounding the people for whom opium cultivation is a major source of income. Heroin also is derived from the opium plant and the international problem of heroin addiction has led to a number of stringent regulations being placed on opium farmers. Opium production was banned entirely in Turkey; this ban had deleterious effects on the Turkish farmers who were financially dependent on opium production. In 1977, the ban was lifted and farmers were once again allowed to grow opium as long as they held a licence to do so and followed government regulations for such production.
General evaluation: Good-Very Good. This highly informative, interesting, and contemporary film was judged to be an effective teaching aid. The group felt the film had a considerable degree of emotional impact and would be a useful film for portraying the complexity of the international drug situation.
Recommended use: Likely to benefit high school students at the intermediate and senior levels. Also beneficial to adults and was judged to be neither harmful nor beneficial for all other audiences.

DEPARTMENT

New Books

by RON HALL

How Much Is Too Much

. . . by Stanton Peele

In this guide the author explores healthy habits and destructive addictions and reveals how to differentiate between the two. The book is not restricted to alcohol or other drug abuse, and illustrates how almost anything, from gambling to jogging, can take on the attributes of an addiction. Guidelines on how to determine when a favorite activity or pastime is tending toward an addiction, and instructions and methods for combating the addictive trend are presented. Establishing healthy habits that are the exact opposite of destructive addictions, and combating addictions through the style in which society raises its children are explained. Chapters are devoted to addiction itself, its sources, disease notions and partial addictions, healthy habits, raising a non-addicted child, the technology of habit control, pressures that maintain and destroy healthy habits, and the non-addicted lifestyle.

(Prentice-Hall, Inc, Englewood Cliffs, NJ 07632, 1981. 141 p., ISBN: 0-13-424192-4)

Caution, Kindness Can Be Dangerous to the Alcoholic

. . . by Abraham J. Twerski

This book discusses the ways in which those other persons in the environment of the alcoholic inadvertently support the drinking instead of doing those things that would tend to bring the problem to an end; however, the author is not saying that those in the alcoholic's environment are responsible for his drinking. Illustrative cases are presented to help those other persons relating to the alcoholic realize that what appears to be kindness and concern for the drinker are often misguided efforts. One central theme prevails: "In virtually all instances, there is nothing that you can do to change the alcoholic. All that you can do is to stop the kind of behavior that prevents the alcoholic from feeling the impact of destructive drinking soon enough to save himself or herself, and, it is hoped, preserve the family unit." Since those relating to the alcoholic include the employer, physician, clergyman, and counsellor, as well as family members, this book is addressed to all concerned.

(Prentice-Hall, Inc, Englewood Cliffs, NJ 07632, 1981. 174 p., $9.95, ISBN: 0-13-121244-3)

The Politics of Alcoholism: Building an Arena Around a Social Problem

. . . by Carolyn L. Wiener

This volume is based on the premise that social problems are socially defined. It examines the arena that has been built up around the problem of alcohol use. The research focus is on problem perception and on the collective activities that have become organized around the assertion that an alcohol problem exists. The author analyzes the manner in which external conditions have affected the arena's growth: the temperance movement; the significance of the disease concept of alcoholism; the "drinking problem" perspective; the cost-benefit thrust and its consequences in regard to the configuring of public information; the political philosophy of the 1970s, and the resultant increased burden on demonstrating both the alcohol problem and the efficacy of programs. Both process and structural conditions are examined in order to explain their interrelationship in making visible the social problem of alcohol use.

(Transaction Books, Rutgers University, New Brunswick, NJ 08903, 1981. 308 p., $19.95, ISBN: 0-87855-379-7)

Other Books

Alcohol and Brain Research, Idestrom, Carl-Magnus (ed), Munksgaard, Copenhagen, 1980. Proceedings of the second Magnus-Huss Symposium held in Stockholm, September 5-8, 1979. 209 p.

Addiction and Brain Damage, Richter, Derek (ed), University Park Press, Baltimore, 1980. Biochemical and physiological mechanisms; clinical investigations. Index. 350 p. $45.00.

The Community's Response to Drug Use, Einstein, Stanley (ed), Pergamon Press, New York, 1980. Drug use and its control; drug education; research. Index. 369 p. $45.00.

A Fresh Start, Kirkpatrick, Jean, Kendal/Hunt Publishing Company, Dubuque, 1981. 164 p.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Detox Training Programs (Non-Medical) — Feb 22-26, Apr 19-23, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell Street, Toronto, Ont M5S 2S1.

Consulting and the Helping Professions Workshop — Mar 13, Toronto, Ontario. Information: Corpus Information Services Limited, 1450 Don Mills Road, Don Mills, Ont M3B 2X7.

Mental Health Information Systems: Problems and Prospects — May 14-15, Toronto, Ontario. Information: Hincks Lectures, Ontario Mental Health Foundation, Suite 1708, 365 Bloor St East, Toronto, Ont M4W 3L4.

73rd Annual Conference Canadian Public Health Association — June 21-24, Yellowknife, Northwest Territories. Information: Gerald H. Dafoe, Executive Director, Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, Ontario K1Z 8N8.

Fifth World Conference on Smoking and Health — July 10-15, 1983, Winnipeg, Manitoba. Information: Fifth World Conference on Smoking and Health, PO Box 228, Station B, Ottawa, Ont K1P 6C4.

Summer Course in Addictions — July 19-23, Toronto, Ontario. Information: School for Addiction Studies, 8 May St, Toronto, Ont M4W 2Y1.

United States

Family Program For Professionals — Offered once each month, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Establishing Priorities: Personal Skills for Therapists — Feb 15, Detroit, Michigan. Information: Michigan Alcohol and Addiction Association, 29563 Northwestern Hwy, Ste #7 - Bldg F, Southfield, MI 48034.

Alcohol/Drug Series — Mar 3-5, Apr 28-30, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Advances in Alcoholism — Mar 5-6, Newport Beach, California. Information: Kim Hilberg, Raleigh Hills Foundation, 17861 Cartwright Rd, Irvine, CA, 92714.

Fifth Annual Alcoholism Symposium: The Treatment of Special Populations — Mar 6, Cambridge, Massachusetts. Information: Division of Continuing Education, The Cambridge Hospital, Department of Psychiatry, 1493 Cambridge St, Cambridge, MA 02139.

Issues of Sexuality in Alcoholism/Drug Abuse Counselling — Mar 11-13, June 3-4, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Pharmacology for the Alcohol/Drug Counsellor — Mar 22-23, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Group Skills — Mar 24-26, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

American Orthopsychiatric Association 59th Annual Meeting — Mar 29-Apr 2, San Francisco, California. Information: The American Orthopsychiatric Association, Inc, 1775 Broadway, New York, NY 10019.

Third Regional Conference on Substance Abuse — Mar 31-Apr 1, Cincinnati, Ohio. Information: Ann Blankenhorn, Central Community Health Board, 532 Maxwell Ave, Cincinnati, OH 45219.

Employee Assistance Programs — Apr 14-15, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Assessment and Diagnosis For Chemical Dependency — Apr 16, June 8, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

First National Symposium on Psycho-immunology - The Impact of Brain, Behavior and Emotion on Immunity to Disease — Apr 24-25, New York, New York. Information: Institute for Psychosocial Study, 221 East 50 St, New York, NY 10022.

Recover or Repeat — Apr 27, Lansing, Michigan. Information: Michigan Alcohol and Addiction Association, 29563 Northwestern Hwy, Ste #7 - Bldg F, Southfield, MI 48034.

Two Rival Psychotherapies Move Toward Convergence — May 1, New York, New York. Information: Institute for Psychosocial Study, 221 East 50 St, New York, NY 10022.

Outcome Evaluation for Alcohol and/or Drug Treatment Programs — May 6-7, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Pastoral Training for Chaplains in Rehabilitation Settings — May 10-12, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Scholarly Communication Around The World - The 27th Annual Conference of the Council of Biology Editors, The 3rd International Conference of Scientific Editors and The 5th Annual Meeting of the Society for Scholarly Publishing — May 15-20, 1983, Philadelphia, Pennsylvania. Information: 1983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Services, 2100 Arch St, Philadelphia, PA 19103.

Nursing Series - Pharmacology, Detoxification and Withdrawal: Basic Skills, Counselling Skills for the Nurse — May 17-21, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Abroad

12th International Institute on the Prevention and Treatment of Drug Dependence — March 22-26, Bangkok, Thailand. Information: International Council on Alcohol and Addictions, Case postale 140, Ch - 1001, Lausanne, Switzerland.

ALC 82, International Conference on Alcoholism — Mar 30-Apr 4, Oxford, England. Information: Dr Phillip Golding, Broadway Lodge, Oldmixon Road, Weston-super-Mare, BS24 9NN, Avon, England.

10th International Conference of Social Gerontology — May 26-28, Deauville, France. Information: ICSG, 91, rue Jouffroy, 75017 Paris, France.

First Nordic Congress on Traffic Medicine — June 8-11, Linköping, Sweden. Information: Mr Leif Bohlin, Congress Director, Linköping University, S-581 83 Linköping, Sweden.

28th International Institute on the Prevention and Treatment of Alcoholism — July 5-9, Munich, Fed Rep of Germany. Information: International Council on Alcohol and Addictions, Case postale 140, Ch - 1001, Lausanne, Switzerland.

Second Biennial AU School of Justice Institute on Juvenile Justice — July 11-30, London, England. Information: Dean Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

11th International Conference on Health Education — Aug 15-20, Hobart, Tasmania, Australia. Information: Joy Faldt, Australian Society of Health Educators, PO Box 818, Fortitude Valley, Queensland, Australia 4006.

Fourth World Congress for the Prevention of Alcohol Problems, Alcoholism and Drug Dependency — Aug 29-Sept 2, Nairobi, Kenya. Information: ICPA — International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St NW, Washington, DC 20012.

33rd International Congress on Alcoholism and Drug Dependence — Oct 9-15, Tangier, Morocco. Information: Archer Tongue, International Council on Alcohol and Addictions, Case postale 140, Ch-1001 Lausanne, Switzerland.

'Bad apple approach' worsens situation

Nurses' drug problems are cloaked in denial

By Wendy Wright

"It's time we started treating it as a disease instead of allowing it to continue until a nurse dies or until a patient dies."
That's Millicent Buxton speaking. The "it" she wants regarded as a disease is abuse of chemicals by nurses.

Ms Buxton calls herself a "nurse advocate." She's concerned about the welfare and rights of nurses. Along with a registered nurse, she runs a group for chemically dependent nurses in the San Francisco Bay area. They operate under the auspices of the Haight-Ashbury Free Medical Clinic, which also runs a group for chemically dependent doctors.

Ms Buxton says there are 1.5 million practising nurses in the United States; about 75,000 of them are considered to be alcohol dependent. Another 45,000 are believed to be dependent on drugs, a higher proportion than normally found among women not involved in the field of medicine.

Much has been written in the last few years about chemically dependent physicians. Not so for nurses. Physicians as a group have a greater social value and visibility; the drama associated with the notion of the impaired physician holding the scalpel, making the wrong diagnosis, or writing the wrong prescription attracts immediate attention.

But the nurse addicted to opiates poses just as great a life-and-death threat to the community. Ms Buxton works with some nurses who had built up such tolerance to Demerol that they were using 1300 mg of the drug on one shift. By the time they returned to work the next day they were in withdrawal.

Ms Buxton's group began in March, 1981. Most of the 21 nurses in the group were referred by the California Nurses' Association. Some have come from other treatment centres. A few have been well for years but meet with new members weekly to share problems and give and find support. Together they work out problems they have in common such as dealing with work-related issues; dealing with stress in a non-chemical way; and dealing with if, when, and how they should return to work.

Ms Buxton says some group members cannot return to work in an environment where drugs are so accessible. For some, this means creating a whole new career. Others are in the group as a condition to having their licence to practise reinstated.

Some were fired by their employers at the time they were reported to the licensing board. They have to wait long periods for their cases to be heard by appropriate committees. In the meantime, they have been away from nursing and getting help through Ms Buxton's group (and possibly other treatment centres). Frequently, by the time a nurse has her case heard, she is already on the road to recovery. Her licence is reinstated. Now she has to deal with the anxiety of returning to work.

Handcuffed

Many members of the group have legal problems. Ms Buxton tells of nurses who have been removed from work — handcuffed by uniformed police. She says criminal charges are now being laid against nurses "with regularity" in some areas; the Bureau of Narcotic Enforcement in San Francisco is receiving about five calls a month from hospitals with nurses dipping into the drug supply. The group offers lawyers to help guide nurses through their legal battles in the courts and with licensing boards.

Official figures from nursing associations in Canada do not indicate a similar problem in Canada. But that's the official response. It's hard to believe a problem such as this can be contained by the invisible border.

In fact, it is not.

That data do not reveal a problem of chemically dependent nurses in Canada emphasizes the degree of denial. Nursing association officials deny there's a serious problem. In the last five years, 91 registration hearings were held in Ontario. (A committee assesses a registrant's physical or mental capacity to practise safely.) But that figure lumps together cases of mental illness and chemical abuse; and it only reflects the cases reported to the College of Nurses of Ontario.

In 1980, only nine hearings were held by the Registered Nurses Association of British Columbia. Again, a spokesman could not determine how many of those dealt with chemical abuse.

The Registered Nurses Association of Nova Scotia won't reveal any information at all on the subject. A spokesperson for the group claims "very few (cases of chemical abuse) come to the attention of the association." At the same time, she admits they are aware of the trend toward an increase in abuse of drugs and alcohol.

But there are no data. And information on cases they do have reported to them is not available to anyone — not even their own members.

Millicent Buxton sees the nursing profession dealing with this problem the same way the American Medical Association dealt with the impaired physician before 1975.

It was the "bad apple approach." The case of an impaired physician was considered an isolated incident. If that doctor could just be weeded out, the problem would be dealt with adequately. Now 40 states have treatment centres for doctors who are addicts. For nurses, the problem only gets worse the longer it is denied.

Says Dorothy Wylie, vice president, nursing, Toronto General Hospital, the problem of the impaired nurse "is underground. It just hasn't surfaced (in Canada) yet. And it won't until it's a blatant problem."

Ms Wylie recalls "three or four cases" in the past seven months of impaired nurses turning up for work and says, "my gut reaction is that it's definitely on the rise."

She finds the alcohol dependent nurse can hide her addiction better than the drug dependent one. The drug dependent nurse doesn't surface until "it's too late," she claims. By then she is too drugged or too desperate to be careful with her theft or her behavior at work.

The fact the raw data do not support the hunch that Canada is facing a serious problem with impaired nurses does not impress Ms Wylie. She believes Canada is just a few years behind the United States. "We're just on the threshold here," she says.

The Donwood Institute in Toronto has a special followup program for physicians with abuse problems, but not for nurses, although nurses too have special problems in recovery.

Rosemary McNaughton is director of patient care at the Donwood. She would like to see a program such as the one for doctors made available to nurses.

What's her impression of the dimensions of substance abuse among nurses? "We're part of the 'ostrich syndrome.'" If we bury our heads in the sand much longer, the numbers will surely reach levels suspected in the US . . . if we're not there already.

Ms McNaughton says 25 nurses — at the very least — come to the Donwood for help each year. And that figure is on the increase. She tells of one nurse she counselled; the nurse was severely addicted to Demerol. She was getting the drug at work. But she admitted she was not the only nurse on the floor removing drugs from the medicine supply. There were others. But they have not yet sought help . . . so they are not yet on anyone's statistic sheet.

Nurses themselves are having trouble dealing with the problem, both as a group and as individuals.

Reluctant

Confronted with the possibility that a peer is working while impaired, nurses are reluctant to report a colleague to a supervisor. More likely, they'll cover for her. If a nurse is having trouble at work, other nurses will help her complete medical procedures — or do them for her — before they will report her. They'll do this until they resent her for causing their workload to become unbearable. Then, they'll report her because they get angry. Had they acted while they were still supportive, she might have benefited from their support. Instead she stands to lose her job and her friends.

There's a pattern of "shrinking" from responsibilities that is common among substance-abusing nurses. Often, they go from job to job, changing when they suspect they have been detected. Frequently, they request the night shift; there is less supervision then, freer access to drugs, and fewer demands made on time. At last, there's the transfer to a nursing home where nurses are in short supply and standards of care less demanding. It does not necessarily follow that the above changes indicate a problem with substance abuse. But they may.

Rosemary McNaughton of Donwood agrees with Millicent Buxton that nurses need their own peers to help sort out their lives and turn things around for themselves. There are feelings of guilt. The Haight-Ashbury group claims their members wrestle with guilt and shame when they begin to face their history of drug and/or alcohol abuse.

In a sense, it is a story of abuse of public trust — especially for the abuser who availed herself of hospital drugs and who has been treating herself to her vice at the expense of the taxpayer. She has betrayed a personal and professional trust. Among other things, there's the need for psychological support from peers — support without judgement; caring, understanding support.

Asking for and receiving help does not come easily for most nurses. They see themselves as "caregivers," not care consumers. Their identity is closely tied up with their nurturing role. Rosemary McNaughton says it's difficult for the nurse in therapy to 1) get over the guilt and 2) see "herself as a human being first" — a person with her own set of needs, rather than a focus on the needs of others.

This collective identity of nurses as caregivers not only makes rehabilitation traumatic, but can also be viewed as a contributing cause to the problem of the nurse as the drug or alcohol abuser.

Mary Vachon of Toronto's Clarke Institute of Psychiatry has done work in the area of stress. She discusses the causes and effects of stress on nurses in a paper: Care for the Caregiver.

Depression is part of the repertoire of common responses to stress. Dr Vachon describes how women are socialized to need to nurture. The nursing profession allows nurses to act out this need. "Women are especially prone to depression because they have not been socialized to think of themselves as primary people; their identity evolves only through caring for others," she writes. So when nurses try rejecting this role as the nurturer, others tend to resist.

While nurses, as a group, are becoming better educated, their roles within the old institutions are not changing fast enough to keep pace with changes among nurses. Frequently, when nurses try to expand their roles, they meet with resistance. The nurse who — against her will — is restricted to the traditional role of the nurse, is a prime candidate for depression. She is left with a poor self-image because she cannot be a creative actor in her own drama. She's a powerless victim. It's a depressing role.

So why are some nurses responding to stress or depression by abusing drugs or alcohol?

In an interview, Mary Vachon points out that nurses are accustomed to giving their patients drugs to help with a variety of problems. It's not difficult to assume that if those drugs are helping patients with *their* problems, "why not me?" When it comes to giving out medications, sometimes it's "one for you and one for me." Dr Vachon suspects some nurses rationalize the abuse of tranquillizers and sedatives by assuming "if patients need pills to sleep, so do I."

As for the nurse who abuses alcohol, Dr Vachon suggests one explanation is the "rough day." The nurse begins by taking a drink when she gets home from a rough day. At some point, she turns her reasoning around and creates in her own mind the notion that "today was a rough day" to justify the drink she pours herself after work — every day.

It is Ms McNaughton's impression that alcohol abuse is on the increase among nurses. Anyway, studies show that alcohol consumption is on the rise among lay women. In addition, she theorizes that since the training of nurses was handed over to the community colleges, alcohol is more readily available. Previously student nurses lived in strictly supervised residences. Now they are part of the campus crowd; there are fewer restrictions on their personal lives. And Ms McNaughton suspects they are picking up their drinking habits in school and carrying them over into their professional years.

Social drinking is generally acceptable behavior among nurses. Often it is *expected*. Nurses earn decent salaries now; it's not difficult for them to afford alcohol. In addition to the stress and demanding nature of their work, shift rotations make sleep patterns unpredictable. At some point, when the nurse finds herself exhausted, stimulants and sedatives may start to look appealing.

Victims

Nurses are victims of their own institutions — the medical model of disease.

The medical model views disease as a deviation from a baseline which can be measured by biological variables. The bio-medical model of illness ignores social, psychological, and behavioral aspects of illness. So the stress caused by day to day problems of the nursing profession is interpreted as psychological "symptoms" of disease. If it's a medical problem, it needs a medical treatment: medication.

The problem with the bio-medical model is that it pinpoints the locus of illness in the individual. It's always the individual who needs the treatment. For nurses, this will only delay the kinds of institutional changes so many of the profession's members want to see.

It's time for medical and lay people to begin discussing problems of chemical abuse by nurses. It's time to roll back the carpet and see what has been swept under it.

Nurses too have to stop denying it. There is a phenomenon known by nurses as "institutional co-behavior." This occurs when co-workers and, perhaps, supervisory personnel, are aware of a problem, but because of misdirected helping styles ignore it; or at least fail to act on it in a way that helps.

The net effect of this institutional co-behavior in nursing is that the chemically dependent nurse continues to practise, continues to use drugs, and becomes an increasing hazard to herself and others.

THE BACK PAGE

Vol. 11 No. 3 2nd Class Mail Reg No. 2776 TORONTO, March 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Cocaine: trouble ahead? ...p4

Political, diplomacy consequences feared

US cheers aggressive Thai opium action

Anne MacLennan reports from Vienna

VIENNA — While the world community braces itself for a heavy new influx of Southeast-Asian heroin, there are fears that international development programs and political stability in the north of Thailand are in jeopardy.

The fears focus on a major new move by the Thai government to eradicate opium poppy crops in the Thai section of the infamous Golden Triangle.

They were expressed privately here by experts from developing and developed countries at the meeting in February of the United Nations Commission on Narcotic Drugs.

Viewed with particular alarm was the possibility the Thai action was in response to pressure from the United States, suggesting a return by the US to its earlier hardline policy: wipe out supply of drugs and we'll wipe out demand.

This view was bolstered by knowledge that Thailand receives millions of dollars in direct US aid for anti-drug efforts, and by a report last year in the *New York Times* (in October) that the US was using the promise of more aid to coerce Thailand into more aggressive crop eradication.

Dominick DiCarlo is the new man in President Reagan's top international narcotics post. Assistant secretary of state for international narcotics matters, he led the US delegation this year to the UN meeting, his first.

DiCarlo: clearly Thai plan.

In an interview with **The Journal**, he said the idea for the eradication program was Thailand's. But he left no doubt about his or the US's position.

"I visited Thailand the end of August and prior to that time the Thais announced they were going to do certain things on the eradication side.

"I would like to take credit for the program but it was clearly the plan of the Thais."

He said the US encourages all nations involved in production of opium to curtail production and had expressed hopes to the Thais that they would "prove" their willingness in this area.

"I believe all of us wish the Golden Triangle crops could be wiped out," he said.

Some experts agree with the end but not with the means.

They point out that crop substitution and primary health care programs have taken time and "quiet diplomacy" to establish, and hinge on cooperation with tribal villagers who cultivate the opium.

They fear 10 years of building and effort could be wiped out as the villagers learn of the destruction.

There are some 250 opium-producing villages scattered through the area. For now, there is uncertainty about how many and which have been affected. Some reports say 10. Others eight.

However, a Southeast-Asian expert at the meeting told **The**

(See — Bumper — page 2)

RCMP launches high-finance units to nab rich drug criminals

VIENNA — The Drug Enforcement Branch of the RCMP (Royal Canadian Mounted Police) is establishing special units across Canada to follow the financial trails of suspected drug criminals.

It's the first time major financial investigations will be carried out by narcotics officers in Canada. The aim is to root out the fabulously wealthy and frequently innocent-appearing people at the top of the drug crime pyramid.

At the same time, the force is going to push for new laws and procedures to aid further in identification, seizure, and forfeiture of assets derived from drug trafficking.

Superintendent Rod Stamler, officer in charge of the drug branch, told **The Journal**: "There's more money available from drugs now than from any other unlawful activity . . . people net hundreds of millions of dollars in very short order."

He said the "very high level of profit" is a threat at several levels.

"In Colombia, there are towns being taken over by organized crime. That's power. From there, they can make contact with Canadian criminals and the money flows.

"Once that money is deeply entrenched in a community, many think they can buy their way into our institutions," he said.

He noted a similar program has been established for some time in the United States giving cause for concern that top traffickers there, frightened off by tougher financial controls, will move to Canada.

The Anti-Drug Profiteering Program, designed to trace and seize assets related to drug crimes, will operate under general criminal law which says it's an offence for anyone to possess any proceeds or assets from criminal activity.

Supt Stamler pointed out that although financial investigations are not new to the RCMP, they are to narcotics officers. In the past, such investigations have been limited largely to the broader area of commercial crime. While drugs may have been involved, they were not a focus.

"We will also use income tax law to facilitate the recovery of a portion of the funds which can be identified as profits of illicit drug trade," he said.

As for the new laws and procedures, in a statement here to the United Nations Commission on Narcotic Drugs, Supt Stamler said three factors must be considered in formulating them.

The laws must 1) provide ways of identifying sophisticated money laundering systems; 2) provide offences and penalties to deal with secondary criminal acts associated with concealing cash flow; and 3) be capable of heing carried out outside of Canada.

"Criminals will take full advantage of foreign international banking systems — especially those protected by bank secrecy laws. We can expect the use of tax haven countries to launder money will increase."

Traditionally, said Supt Stamler, the RCMP have concentrated efforts on seizure of illicit drugs and the arrest of couriers and traffickers — "the lowest levels of the criminal organizations involved in illicit drug distribution systems."

"The people at the top are so removed, they don't even make contact with the people on the drug side. They are protected by an empire."

Recently, he told the UN, "we have successfully used our conspiracy laws to reach even higher into the criminal organizations . . . to those planning and directing trafficking."

Prior to his 1980 appointment to the drug branch, Supt Stamler had had extensive experience in commercial crime investigation and there was considerable speculation the experience would be heavily applied in his new position. Immediately prior to his move, he was at the National Defence College for a year.

New influx of heroin entering Canada

VIENNA — Heroin, cocaine, "chemical drugs," and marijuana — in that order — will be the priority drugs this year for Canada's Royal Canadian Mounted Police (RCMP).

Stamler: crime to increase.

New supplies of heroin originating in Southeast Asia are already being seen in Vancouver, Ottawa, Toronto, and Montreal and there will be more use and more overdose deaths, Superintendent Rod Stamler, officer in charge, Drug Enforcement Branch, told The Journal **here.**

"There'll be more supply, more experimentation, more addicts, and more overdose deaths," he said.

"Crime rates will also go up; the addict has to go out and commit crimes. That's what's hard on communities."

Cocaine from South America is also on the increase, and use threatens to "increase dramatically," he said.

"If it continues, it will be like marijuana. The only thing keeping it down now is price."

Enforcement concern around chemical drugs — methaqualone, amphetamines etc — centres on the fact distribution is largely in the hands of "motorcycle gangs," said Supt Stamler.

"They've got their own army. The grey army of young individuals on the frontlines. They're difficult to handle, difficult to control."

In addition, the more powerful gangs have counterparts around the world, he said.

"If they connect internationally the way it looks like they're trying to connect . . . it could become a very serious problem in the long term."

Marijuana? "Pot is the last priority and hopefully use will level off. In this area, we have to concentrate our efforts on major importation cases," he said.

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NEWS

Briefly. . .

Beer causes 'blues'

KITCHENER, ONT — A long-time customer has tried to sue Labatt's Breweries for $1,000 for "pain and emotional trauma." Last year, as Mike Cziklin, 43, was drinking a bottle of his favorite brand, a blob of slimy grey mould went down the hatch too. The results: immediate violent illness, four months of headaches, and six months of fear-induced abstinence from Labatt's Blue. That's not all. It was a full month before Cziklin was able to return to his two or three bottles per day — which he can now stomach only out of a glass. Although Judge J. E. Clement reserved judgment in the case, he told the Labatt's lawyer: "You should give him some money just for the advertising you're getting."

Pet pig a smoker

WELLINGTON, NZ — If it weren't for his pet pig's habit, a man charged with growing marijuana would have gone to jail. Police found 380 marijuana plants near Brian Churcher's farm, where he lives with his pet, Barry. The porker, it turns out, is a head. "One smokes it and one eats it," a policeman testified in court. The judge accepted that some people could share their drugs with pigs — "otherwise you'd be going to jail." He ordered the plants destroyed and sentenced Mr Churcher to 75 hours of community service.

Quaalude scripts

NEW YORK — Methaqualone (Quaalude), primarily an illicit street drug, is now being prescribed by physicians working at "stress centres" in many United States cities. A Federal Grand Jury in New York is investigating whether such centres, which also claim to treat insomnia, are actually fronts to peddle the drug. According to *The New York Times*, doctors at stress centres can make more than $1,000 per day because of the large number of patients. The New York State department of health reports that 80% to 90% of all methaqualone prescriptions (more than 24,000 for January to September, 1981) are written by such doctors.

Solution spots addict

FLORENCE, ITALY — A quick, safe, and foolproof test of heroin addiction has been developed by pharmacologists here. It consists of putting a few drops of naloxone solution into a patient's eye. If the pupil dilates markedly within 30 minutes, addiction is indicated. The new test is said to have no systemic effects and can be easily administered by medical aides or police officers.

DWI Judge on bench

VANCOUVER — For his second conviction for drinking and driving, former British Columbia Supreme Court judge and federal cabinet minister, E. Davie Fulton, has been sentenced to 14 days in jail. But in a recent decision by the Law Society of BC, Mr Fulton, 65, may continue practising law as long as he continues his alcohol rehabilitation program.

US Congress fears FBI/DEA merger

By Harvey McConnell

WASHINGTON — The United States Drug Enforcement Administration (DEA) will be under direct control of the Federal Bureau of Investigation (FBI) in plans announced by the department of justice.

It is expected that Francis Mullen, who has been administering the DEA since the resignation of Peter Bensinger last July, will be nominated as permanent DEA chief. Mr Mullen was one of three executive assistant directors of the FBI.

Although combining the DEA and FBI may well help in combatting drug trafficking in the US, many in Congress are worried about the international ramifications.

Despite the efforts to end serious abuses of power by the FBI in previous years, they believe it will be harder for DEA agents to operate abroad with this incubus of the past.

William French Smith, attorney general, said the reorganization brings "the full resources of the FBI to bear on the problems of domestic drug trafficking. I am confident that an infusion of FBI resources to supplement those of DEA will aid immeasurably in our nation's drug enforcement effort."

Under the plan, the FBI will become involved in drug trafficking cases related to organized crime.

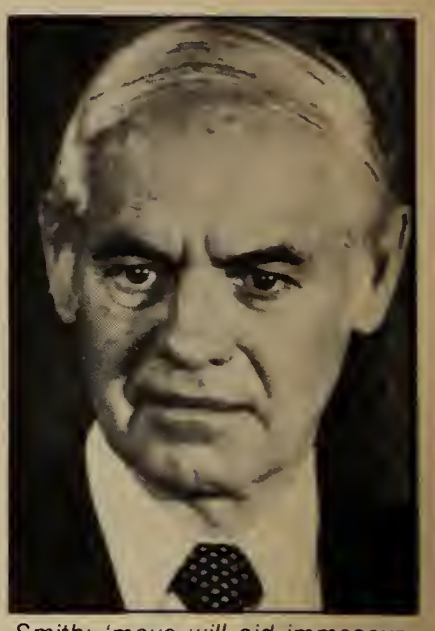
Instead of reporting directly to the attorney general, the new DEA chief will report to FBI Director William Webster, and he, in turn, will report to the attorney general.

Attorney General Smith would not say definitely that the reorganization will not require additional funding by Congress.

Mr Smith said the merger will involve rotating FBI and DEA agents within the agencies. Since July 1981, joint investigation have increased from 15 to 125 cases.

One problem still to be addressed is the status of the agents; FBI agents have to be college graduates and are in a special category of employ and can be hired and fired by the FBI director without normal civil service protection. DEA agents are regular civil service employees and do not have to have college degrees.

Mr Smith said the differences could be eliminated by action from the administration and from Congress.



Smith: 'move will aid immeasurably in nation's enforcement effort.'

Pharmaceutical companies relieved

Reagan vetoes Rx drug warnings

WASHINGTON — Efforts to get United States pharmaceutical companies to provide warning leaflets with 10 widely-prescribed drugs, including Darvon and Valium, have been scuttled by President Reagan's administration.

The proposal, which took years finally to come to fruition within the Food and Drug Administration (FDA), was pushed by consumer groups and many in the substance abuse field.

Many doctors, pharmacists, and pharmaceutical companies opposed making the brochures mandatory — they wanted a voluntary effort by the pharmaceutical companies. The industry was quick to voice approval of the axing of the proposal, which would have gone into effect in May.

Richard Schweiker, secretary of health and human services, said the pilot program for the 10 drugs had "significant limitations" and would "impose unreasonable restraints on the health care system."

He did not spell out what he meant.

Secretary Schweiker announced formation of a Committee on Patient Education to "provide a focal point for the activities of the FDA and other government agencies active in educating consumers about prescription drugs."

This drew an immediate retort from Jere Goyan, FDA commissioner under President Carter, who initiated the proposal.

Dr Goyan said: "This administration seems to specialize in new terminology for old ideas." In economic terms, "supply side" has replaced "trickle down" and now "freedom of choice" is a euphemism for "caveat emptor" (let the buyer beware), he said.

The proposal was opposed by pharmacists, who said it would cost them millions of dollars in extra labor and in returned prescriptions. Some doctors claimed patients might read the leaflets and decide not to take the prescribed drug.

Schweiker: unreasonable restraints.

Activists want ban on Placidyl

WASHINGTON — A consumer action group has asked the United States government to consider either banning or limiting the prescribing of the sleeping compound Placidyl (ethchlorvynol).

Sidney Wolfe, director of the Public Citizen Health Research Group, said he wrote to the department of health and human services requesting the restrictions because Placidyl "is yet another example of a doctor-induced drug abuse of massive proportions."

It was widely reported that Supreme Court Justice William Rehquist had been taking Placidyl, and when doctors sought to cut back the dosage he underwent a severe withdrawal at George Washington University Hospital. A spokesman said Mr Justice Rehquist suffered from a temporary loss of mental clarity and perceptual capability.

Dr Wolfe said the drug endangers thousands of people. A ban or prescribing restriction would help in lowering its abuse as consumers become more aware of the dangers.

The Drug Abuse Warning Network (DAWN) reported in 1980 some 1,828 emergency room visits related to Placidyl, and medical examiners reported 103 deaths.

'Slashed funds horrible precedent'

US field battling insurance issue

WASHINGTON — Hard lobbying is being applied by the substance abuse field to the United States Congress to counteract a "great leap backwards" by President Reagan's administration in slashing insurance coverage for federal workers with alcohol problems.

More than a dozen organizations have agreed on provisions which they hope will be tacked on legislation to restore coverage for federal employees with either alcohol or other drug problems.

After only one year in operation, the Reagan axe has truncated coverage by removing all treatment, rehabilitation, and related services, other than acute detoxification, for employees with alcohol problems.

Roger Stevenson, executive director of the US Alcohol and Drug Problems Association (ADPA), said: "We are getting a lot of calls from our members who are worried. And it is not because they treat a lot of federal employees, but they recognize if we get a precedent coming out for federal employees, there may be a domino effect, so to speak, and we may lose alcohol coverage in all kinds of private plans. It is just a horrible precedent."

Bumper opium crop moves west

(from page 1)

Journal; "If we lose it (Thailand) we lose a major opportunity. It's one of the few countries in which there can be a real test of various programs."

Canada is one country involved in health-care development aid to the north of Thailand (The Journal, Aug 1, 1980).

H. David Archibald, consultant on international activities, Addiction Research Foundation, and a World Health Organization consultant, said this: "A very basic point is that it has taken several years to establish a line of communication and acceptance on the part of the villagers so they'll cooperate.

"If we destroy that, it sets the issue back by years."

Meanwhile, the UN warns that a bumper crop of poppies in Southeast Asia is threatening to flood the world blackmarket with as much as 600 tons of opium. It will move westward mainly in the form of heroin.

In a report to the commission, the International Narcotics Control Board (INCB), suggested more than half the region's illicit opium is thought to come from northeast Burma.

Illegal production also increased in Thailand, said the INCB, with Bangkok continuing to be the main outlet for Golden Triangle opiates, as well as an important trafficking centre.

This three-fold increase over 1980 will augment "enormous quantities" of opium already flowing from the Middle East, also mainly in the form of heroin, said the INCB.

DAWN moves to NIDA

WASHINGTON — The United States National Institute on Drug Abuse (NIDA) has assumed all responsibility for the Drug Abuse Warning Network (DAWN) reporting system.

The system had been operated in conjunction with the Drug Enforcement Administration. Now NIDA has complete financial and operational responsibility.

The DAWN system collects information on adverse reactions related to drug taking at 800 hospital emergency rooms, coroners' and medical offices, and crisis intervention centres in 16 metropolitan areas around the country.

Neil Sampson, director of the system for NIDA, said plans are being made to redesign the data processing procedure and added emphasis will be given to the epidemiology of drug abuse.

Canadian brands with lowest CO yields...

...and highest CO yields

Manufacturers will reduce cigarette CO yields

By Pat Ohlendorf

OTTAWA — Canadian cigarette manufacturers have agreed to lower the carbon monoxide yields of Canadian cigarettes over the next few years, Minister of Health and Welfare Monique Begin has announced.

"This is the culmination of our continued attention to the (carbon monoxide) problem," David Bray, director of tobacco control at the department of health, told **The Journal.**

As with tar and nicotine, reducing carbon monoxide yields is voluntary on the part of cigarette companies.

But, said Dr Bray, "I happen to think it's in the manufacturers' best interest to do so. Their customers might live longer."

Notice of carbon monoxide levels will probably not appear on cigarette packages along with the tar and nicotine contents, Dr Bray told **The Journal**, because "the carbon monoxide will have a similar value to the tar value. The correlation is relatively high, certainly for the lower brands and for filtered cigarettes.

"If the carbon monoxide is equal to or lower than the tar level, then our concern is reduced."

The carbon monoxide yield of a cigarette is measured in milligrams per cigarette, as is the case with tar and nicotine. But because it's a gas, it is collected in a bladder and then analyzed, rather than being collected as particulate matter on a filter. Most of the government's research using smoking machines is carried out through Labstat Inc of Kitchener.

Carbon monoxide interferes with the blood's ability to carry oxygen. Over the past several years research has linked the carbon monoxide in cigarette smoke with heart and respiratory disease and with retarded fetal growth.

According to recent tests by Labstat, the results of which accompanied the minister's announcement, the three Canadian cigarette brands lowest in carbon monoxide are Viscount No 1 Ultra Light (1 milligram), Medallion, and Craven A Ultra Light (2 mgs). The three highest are Mark Ten and Cameo Menthol (22 mg) and Vantage (21 mg).

Hospital patients keep on smoking despite docs' orders

TORONTO — Canadian hospitals are not doing enough to reduce smoking by patients, says an Ontario doctor who studied the problem in his own hospital, Peterborough Civic.

The study, by Steven Senior, published in the *Canadian Medical Association Journal*, found 86% of 257 smokers admitted to hospital over a one-month period continued to smoke while in hospital.

Some of those who continued to smoke probably cut down, Dr Senior told **The Journal**, but that did not count in his study. His focus was on compliance with doctors' orders — and doctors' orders were pretty much ignored.

When patients were *advised* not to smoke, 88% continued. When *ordered* not to smoke, 80% continued. Even when the illness was directly related to smoking, 66% continued to puff.

To clarify the reasons for non-compliance with doctors' orders, Dr Senior looked at the smoking habits and attitudes of doctors, nurses, and other staff at the hospital who came in contact with patients.

Twenty per cent of doctors smoked, as did one-third of nurses and other staff. The majority of these doctors, and virtually all of the smoking nurses and other staff, smoked while at the hospital.

"The problem is that no matter what the health staff says, the patient soon sees that quite a few doctors and nurses smoke and particularly among the nurses many support the right to smoke at the hospital. The patient gets the official message that smoking is dangerous to health but then he or she goes to the cafeteria, sees doctors and nurses smoking, and gets quite a different message," Dr Senior said.

"Cigarette smoke interferes with the treatment of many diseases, very obviously all those diseases directly related to smoking, but also others, such as depression or angina, where smoking reduces the effectiveness of drugs that are typically used."

Smoking within 48 hours of surgery, either before or after, has been related to a higher incidence of post-surgical complications, he said, and is known to be a risk factor in caesarean section patients.

When doctors who took part in the study were asked about possible modifications to the smoking rules at the hospital, 100% wanted a stricter policy than the one currently in force, Dr Senior said.

Three-quarters of the 88 doctors who participated in the study (half the doctors on staff did not) said that a patient with a smoking-related disease should not be allowed to smoke in hospital and 62% said physician consent should be required for any patient to smoke in hospital.

One doctor in four supported a complete ban on smoking in hospital, a ban which would include doctors and other staff. An equal number believed stricter policies than the present ones are impractical.

At least for the present, Dr Senior said, those who believe nothing can be done are winning. Despite the support the majority of doctors give in theory to tougher policies, nothing at Peterborough Civic has changed after nine months of lobbying by Dr Senior.

Dope book a good read for addictions pros

By Wayne Howell

Memo to Harper and Row Publishers
New York, NY
Re: *The Dope Chronicles 1850-1950**

I imagine you had high hopes for this 300 page large-format book when you puolished it in 1979. It was a good idea: assemble a collection of daily newspaper articles on drugs over the course of a century, put them together in a montage, organize them according to subject, and invite the reader to browse. After all, who could resist headlines such as these making their way in alternating type-face down a narrow column of the May 13, 1905 *New York Herald:*

HINT OF PLOT TO EITHER POISON OR DRUG MRS GOULD/ Name of Negress Mentioned in Court in Connection with a Virginia Episode/**MORE TIPPLING TALES AND CURSING STORIES/** Former Servants Testify That in Their Opinion the Plaintiff Took Too Many Drinks/**SAY SHE SWORE VERY OFTEN/**Coaching Drives are Recalled and Also Occasions on Which Mrs Gould is Said to Have "Reeled About."

Or these, from a 1923 Hearst newspaper:

MARIJUANA MAKES FIENDS OF BOYS IN 30 DAYS/HASHEESH GOADS USERS TO BLOOD LUST

Well, it appears that a great many people could resist them, and did, because I just picked up your book at my local bookstore for the remaindered price of $1.99.

What went wrong? I suggest that your marketing strategy was faulty. The book appears to have been designed to appeal to the counter-culture market. I'm sure you thought the people who think marijuana must be a harmless drug because Reefer Madness was such a silly movie would love this book — just as they loved *The High Times Encyclopedia of Recreational Drugs* which sold well at $12.95 a copy the year before. But for one reason or another (too much text and not enough pictures?) they didn't, and the book ended up on the remainder table along with the usual autobiographies of furniture refinishers and histories of Yugoslavian tablecloth design that one finds there.

I think you went about things the wrong way. I think if you had promoted this book to people employed in the addictions field you would have had a modest success on your hands. They would be amused by the more flagrant idiocies beloved by the *High Times* crowd (such as the 1923 Lions Club luncheon plea by Dr Isham Harris, head of the Brooklyn State Hospital, for more funds to build hospitals to accommodate those about to be made insane by listening to jazz on the radio late at night). But they would also appreciate the more subtle ironies. They might, for instance, note as I did that while the newspapers railed against drugs with almost hysterical vigor, they were not adverse to accompanying the articles with illustrations that can only be described as sexually titillating.

A long article about the evils of opium smoking in a 1924 newsmagazine is incongruously accompanied by a reproduction of Matignon's, *The Opium Smoker.* The to-the-navel décolletage of the beautiful young woman reclining on a couch, pipe in hand, is the kind of thing that would draw protests from the readers of a "family" newspaper were it published today.

A 1943 article about the dangers to youth in wartime New York describes Rita, a "victim of marijuana," being "half led and half carried out of a dingy doorway by two sinister and swarthy youths." But in the illustration the victim appears as a blissful Rita Hayworth and her two abductors are anything but swarthy — they look like two male leads from a 1930s society movie.

This kind of mixed-message reaches its apotheosis in a 1915 *New York World* article on cocaine use in Paris. The *Sketches of the Unfortunate Women in the Cabarets and Opium Dens of Montmarte* are rather remarkable. It is true that "Little Pale Jeanne No 1" who is painted in the Toulouse-Lautrec manner does look a bit rough, but "Little Pale Jeanne No 2" and "Little Pale Jeanne No 3" are as plump and ravishing as any women Auguste Renoir ever immortalized on canvas. They seem to be holding up rather well, as do the three Ziegfeld Follies-type lasses reclining in a 1924 photograph of *A Dirty Opium Den in New York's Chinatown, Where Men and Women of All Grades of Society Meet in Common Degradation as Slaves of the Drug".*

Sometimes, of course, the ironies are not so subtle. Take, for instance, this series of headlines which comes not from the Oct 1, 1981 *Miami Herald*, but from the October 1, 1891 *New York Herald:*

A PARADISE FOR SMUGGLERS/Over One Million Dollars' Worth of Opium Annually Brought into the United States from British Columbia/**CHINAMEN COMING IN DROVES/**Utterly Useless Precautions of the Treasury Department Against an Organized and Lucrative Business/**HOW IT IS MANAGED/**Tortuous Inland Channels Offering Scores of Paths for the Adventurers from Victoria to the State of Washington/**CANADA PROFITS AT OUR EXPENSE/**A large fleet of Vessels Maintained, Good Telegraphic Service for the Law Breckers — One Steamer and Slow Wires for the Government.

There is very little new in this book for people involved in alcohol and drug treatment or prevention programs; they are familiar with the history of drug use on this continent and know about turn-of-the-century opium parlors, jazz-age drug shenanigans, prohibition, and so forth. However, unless they have spent a lot of time rooting around in dusty newspaper archives I doubt that they have had an opportunity to peruse this kind of primary source material in any detail. I think they would enjoy doing it. Dabbling in this collection of voices from the past does not lead to many profound thoughts, but it does reward you with little insights from time to time, and it is fun. I'm going to suggest that people in the addictions field try to obtain copies of your book.

Yours truly,
Wayne Howell

*(*Published in Canada by Fitzhenry and Whiteside Ltd, Toronto.)*

NEWS

'Social' drug users neglect lessons of history

Naiveté, false optimism veil cocaine/pot hazard

By Harvey McConnell

WASHINGTON — History may be a great teacher but many people today seem hell-bent on not remembering the lessons of cocaine.

"The striking thing is that, always, it is almost as though we have poor memories, and we are compelled to repeat the lessons of the past simply because we think of each rediscovery of a drug as representing a new revelation. And we don't even look at what happened in the past," believes Robert Petersen, PhD.

Dr Petersen has decided, "at a relatively young age," to leave government service after 25 years. He was author of the annual *Marijuana and Health Report* to Congress from the United States National Institute on Drug Abuse (NIDA), editor-in-chief of NIDA's monograph series, and assistant director of research.

He points out that the use of cocaine in the late 19th century in what had become a modern industrial society "provided some object lessons which are even now being ignored.

"The obvious reality is that here is a drug which, when given heavier use, means there is no question it results in dependency."

Dr Petersen says there is always "the optimism that accompanies all use" of drugs.

"Don't misunderstand. I don't want to rewrite history. But I, like all of us I think, had a kind of vaulting optimism, particularly around marijuana. Most of us I think really underestimated the hazards, particularly when the use was originally restricted to occasional use.

"Now we are in the process, in some ways, of making the same damn mistakes about cocaine as we see more cocaine use."

The economics of cocaine buying restricts its use at the moment to a narrow group of financially well-to-do. "But as we get more and more people who use cocaine, we have problems.

"In fact, if, for whatever reasons, it became economical to produce, or to introduce, larger quantities of cocaine into the US at a lower price, I think it would be a disaster."

Since leaving NIDA, Dr Petersen has joined the board of the American Council on Marijuana (**The Journal**, Sept, 1981). This month he starts, with Dr Robert DuPont, the council's president, the first group programs to try and help adults break their marijuana habit.

He explains: "We are finding ourselves with a number of people dependent on marijuana in much the same way people have become dependent on other drugs, including alcohol. It is more and more obvious that, from conditions of regular and heavy use, marijuana is not without its serious problems.

"I think the most interesting thing that has come out of the last couple of years is really a growing awareness that casual, or occasional, use by young adults has quite different implications, probably, than heavy use by kids, especially, and by older adults."

Dr Petersen says he is among many who thought, back in the 1960s, that marijuana use "would never become as extensive as it became, and it would never involve as young a population as it has now come to involve. I think that is where we missed the boat."

While as a public health scientist Dr Petersen always sounded a tocsin of caution, as a researcher he can also evaluate precise data, as well as observe pragmatically what is happening.

"A striking thing to me is that in our zeal to establish some long-term, permanent health hazards, we have ignored, for example, the very obvious one that getting stoned or getting drunk every night is not a good idea while you are developing, particularly, or at any point in your life.

"In a funny way, it's the denial of the obvious while looking for the subtle. Lung cancer is an outside, long-term possibility if you use heavily for a long period of time. But the fact it interferes with function, right at the time while you are stoned, is obvious to any user."

A supreme irony, he says, is that while a decade-or-so ago many people discounted cautions expressed by some scientists because of the climate in which the cautions were presented, today many young people are not waiting for the scientific evidence of harm which, perforce, emerges slowly.

Dr Petersen: "I think what is happening is a second reconsideration. We are gradually recognizing that initial optimism that this would be a safe, recreational drug was misplaced, and that even the users themselves, kids in particular, are increasingly reticent about becoming involved in heavy use.

"The kids are clinically observing that other kids are getting into trouble and they are becoming loathe to use it regularly. I think that is happening in a number of countries, such as Canada and Britain, besides the US"

Dr Petersen ascribes no occult wisdom. Some street-drug users are sophisticated, but many are extremely naive about the farrago of substances they ingest. "It has always amazed me they will put anything into their gut, doing their own 'bioassay' you might say, without regard to what it might be."

The recent history of marijuana must not be repeated with cocaine — "the overstated hyperbole that characterized the 'reefer madness' era. In a way, it has haunted us, and caused a lot of people to fail to appreciate the hazards.

Petersen: recent history of marijuana must not be repeated with cocaine — the overstated hyperbole that characterized the 'reefer madness' era.

"The tendency to want to be absolutely simplistic is a foolishness."

Teaching people to consider the cost of any behavior, including drug use, has to be done slowly and with thought. "But, by God, it is a lot more reliable than telling people they are going to drop in their tracks."

Dr Petersen would like to see more respect for the user in the sense that most are not on a self-destructive bent, but are looking for pleasure, "as aren't we all, in a certain sense, in life. People don't start smoking to get hooked on cigarettes."

What makes the US unusual among industrial countries is that it's a volatile society where fads can sweep with titanic force. "In a decade we moved from a totally under-exercised generation to a health food, jogging generation."

One reason Dr Petersen has moved into counselling heavy marijuana users is because "I have talked to — it must be hundreds now — people who say the man or woman they live with is now a complete dullard because he or she spends their time stoned."

He doesn't doubt most users of drug, "and this includes smokers, drinkers, and God-knows whaters, want to quit, but they want also to become social users, in effect. It may well be, and this is a theory which both Dr DuPont and I share, that after a point in development of a dependency, it is no longer possible to make that sort of return to that kind of use."

Regular marijuana users lead lives which appear similar in some ways to those of alcoholics. Dr Petersen: "They have built their life around drug use, their friends tend to be users, almost everybody they know tends to be in the category of a drug-related person. When you cut this out, how do you develop an alternative lifestyle which is not drug oriented?"

He says that in his long-term study of regular marijuana users, Dr James Halikas of the University of Wisconsin School of Medicine (**The Journal**, April, 1980) found 10% had great difficulty in trying to live a normal life. "It seems like 10% may be the magic number for people who get heavily involved in anything," Dr Petersen adds.

As for his future, Dr Petersen says it is "no secret agenda that the tide of government has turned" in the US. He had the opportunity to retire early "and I can pursue other interests, including writing and a bit of flute playing."

There are times in life when one feels "you have kind of done what you can particularly do in a particular context. I have been privileged to be, if you want to be romantic about it, a principal architect of the drug abuse research effort from its very inception back in the late 1960s. It enabled me to do some exciting things, in an exciting time, and to leave and go on to other things equally exciting, I hope."

As for the future of NIDA, Dr Petersen believes "as long as there are peopte abusing drugs there will be a need for NIDA or a program very like it, although who can say what is the ultimate institutional form it will take.

"Certainly, it is not likely drug abuse is going to go away in our time."

RESEARCH UPDATE/ Austin Rand

Smoking, not coffee, at fault

The suggestion that coffee-drinking increases the incidence of birth defects and low-birthweight (LBW) babies does not seem well-founded, say researchers who have completed a study of 12,000 pregnancies. The study, carried out in the Boston area, found no relationship between heavy coffee consumption (four or more cups daily) and either major or minor malformations. Heavy coffee consumption was associated with a higher incidence of short gestation and low-infant birthweight in preliminary data, but further analysis showed that the apparent association should really be attributed to the fact that a smoking habit frequently accompanies a coffee habit; independent of smoking, there was no increase in LBW babies among heavy coffee drinkers, the researchers say. Noting that only 5% of their sample reported heavy coffee drinking, while 22% were smoking during their last trimester, they add: "It may be more difficult to persuade women to quit smoking than to change their coffee habits, but the benefits from smoking-cessation programs are more likely to be real."

New England Journal of Medicine, 1982, v. 306: 141-145

All smokers inhale

It is wrong to think pipe and cigar smokers do not inhale, says a British research group, pointing to evidence provided by levels of carboxyhemoglobin (COHb). COHb is an indicator of the amount of carbon monoxide in a person's system. Among primary pipe smokers (those who have never smoked cigarettes) the early-morning level of COHb is higher than that found in non-smokers, indicating that their system still retains inhaled gases from the previous day. Also, as the pipe smoker progresses through the day, COHb rises steadily from the early-morning 1.1% (a measure of how much hemoglobin is bound to carbon monoxide rather than oxygen) to 2.6% by the seventh bowl. If he or she is a secondary pipe smoker (with previous experience on cigarettes), the COHb level goes up to 3.3% by the seventh bowl. Someone smoking large cigars inhales enough carbon monoxide to drive his or her COHb level up to 7% by the third or fourth cigar, and a dedicated smoker of small cigars is likely to pass that level. In short, COHb levels of pipe and cigar smokers increase with the amount smoked, indicating that inhalation is going on. Also, secondary smokers typically have higher COHb levels than primary smokers do.

Lancet, 1982.1.2: 40-41

Bulimia prevalence rising

About 5% of males and up to 20% of females in a young adult population suffer from bulimia, suggests a study of summer students at Cornell University. Bulimia, listed in the most recent edition of the *Diagnostic and Statistical Manual* (DSM-III, 1980) as a separate disorder from anorexia, is characterized by recurrent episodes of binge-eating, sometimes accompanied by use of laxatives or forced vomiting. The researchers say that their results suggest a higher prevalence of the disorder than previously reported, although the ratio of males to females is similar to that suggested by a 1980 research report. Most bingers practised weight control through vomiting, medications, or both. Vomiting was more popular than laxative use and 9% of vomiters reported using the finger-down-the-throat manoeuvre once or more per day. There were, on average, two weeks between binges, though the greater the self-perceived weight, the shorter the period between binge episodes. There was no association, the researchers note, between current bulimic symptoms and any history of severe underweight (only one of the 355 respondents reported ever having been anorexic), a fact which reinforces the idea that bulimia is not a subclass of anorexia. Noting that their study had only a 66% compliance rate, the researchers add: "The 34% of the population not examined might contain a large number of bulimics simply refusing to be a subject of investigation."

Psychological Medicine, 1981, v.11:697-706

FAS effects expanded

The range of effects attributable to *in-utero* exposure to alcohol should be expanded to include both impairment of attention and problems in language acquisition, say two Yale University MDs. They base their claim on a study of two pre-school-aged boys, both with significant antenatal exposure to alcohol and strikingly similar peculiarities of appearance and behavior of a kind not previously described in the literature on fetal alcohol effects, the doctors say. First, in addition to typical FAS facial characteristics, each child had a head circumference greater than the 97th percentile, without hydrocephalus or evidence of growth failure. Second, each had a similar pattern of verbal and behavioral dysfunctions characterized by marked hypervigilance, distractability, and cognitive confusion manifesting as anxiety and behavioral disorganization. The two boys were particularly perplexed by social situations and took no pleasure in interactions with other children. They were borderline retarded on verbal intelligence tests but average or above average on non-verbal. This points out the importance, the researchers say, of giving very broad intelligence testing to children with suspected fetal alcohol effects. Early action, they note, can help repair the damage.

Pediatrics, 1982, v.68:850-855

Team study to guide union reps on alcohol

MONTREAL — A Quebec-based labor federation has been granted $126,296 to help combat alcoholism among workers.

The Confédération des syndicats nationaux (CSN), representing about 220,000 workers in Quebec, Ontario, New Brunswick, and Newfoundland, received the money from Health and Welfare Canada to develop an educational program for union representatives on how to deal with alcoholism in the workplace. The aim of the project, said Richard Lapointe, former alcoholism treatment worker turned CSN union adviser, is "to try and stop the advance of alcoholism."

Mr Lapointe and three other CSN consultants — two with experience in both alcoholic rehabilitation and union leadership plus a film director — will produce a videotaped documentary and an accompanying study guide dealing with the issue of workplace alcoholism.

"Because working conditions are great factors in the evolution of alcoholism," says Mr Lapointe, "the union has to try and stop this evolution through the workplace." He hopes to avoid cases where an alcoholic employee will be fired outright because, "this only creates a second problem which will add to the alcoholism."

There's also the concern at CSN that alcoholism will go the route of other industrial problems such as asbestos, and be ignored. Mr Lapointe told **The Journal**: "It's a question of trust and we don't trust the employer."

With this educational project he expects to impress upon workers and employers the importance of clear contracts defining the responsibilities of both union and management in dealing with alcoholic workers.

Mr Lapointe praised Radio Quebec for their recent contract to take some responsibility for rehabilitation of an alcoholic employee there. This is the kind of action he hopes to make a part of every collective agreement.

GILBERT

'. . . the whole matter of alcohol use in Ontario could do with a good airing. . .'

A licence to drink

By Richard Gilbert

Politicians spend a lot of their time worrying about money. Much of this time is spent on the funds they must raise and spend for the public good. A little is spent discussing their own, controversial salaries. A disproportionate share of the time is spent on fundraising for election campaigns, especially when, like me, the politicians hold political views that find little favor with chartered banks and other large business interests.

A staple means of raising funds is the political bash. A few hundred of your friends and supporters buy overpriced tickets for the questionable privileges of being able to fill a church hall, eat, dance, listen to a stirring speech or two, bid for lunch with a party luminary, and buy overpriced alcohol.

In Ontario, of course, you need a permit from the Liquor Licence Board of Ontario (LLBO) to sell alcohol at a fund-raising event. Permits for the sale of alcohol outside of licensed premises were first made available in 1947, when the LLBO was established, although, as the first report of the LLBO noted obliquely, "Formerly liquor was often served in places and on occasions, the legality of which might be questioned."

Babysitter Law

That was the year of three major liberalizations of Ontario's alcohol control laws: (1) Liquor could now be sold by the glass, but only in hotels and taverns. (2) Restaurants could be licensed, but only for the sale of beer and wine. (3) Patrons could be served at the dispensing counter, as long as they were seated.

Also, in 1947, some things were taken away from Ontario drinkers and purveyors of drink: (1) It became an offence to consume alcohol in public before noon; hotel bars and dining rooms had, since 1934, been allowed to sell alcoholic beverages from 10 am onwards. (2) A patron who was also the parent of a child under eight years of age became forbidden to remain on licensed premises while the child was "unattended by a competent person;" failure to provide an adequate babysitter while drinking made the parent liable to arrest without warrant and a fine up to $500. (3) A server of alcohol became liable to a suit for civil damages if a client became intoxicated and, while intoxicated, caused death, injury, or property damage.

The first two of these restrictions have been lifted. From Jan 1 this year, it has been lawful to serve alcohol in a bar or restaurant from 11 am onwards. The requirement regarding babysitters was repealed in 1975. The third is still in place. Waiters can still be sued when their drunken customers maim small children.

From 1947 until 1964, the permits for selling alcohol in unlicensed premises were known as Banquet Permits — sometimes as Entertainment Permits. They were issued chiefly for the purposes implied by their names. The use of these permits increased remarkably, from 9,676 issued throughout Ontario for the first full year of operation of the LLBO, to 74,033 issued during the year ending in March 1964.

New legislation in 1965 renamed the permits and permitted their use for a wider range of purposes. The new Special Occasion Permits could be used for "functions as provided in the regulations." The regulations prohibited only functions "conducted for the purpose or with the intention of gain or profit."

Further legislation and regulation in 1975 streamlined the administration of Special Occasion Permits by allowing the LLBO to delegate issuance to one of its officers, and by authorizing the use of the permits for fund-raising events "conducted for a purpose that will promote the advancement of charitable, educational or religious works or to serve community needs." (The Board has helpfully regarded politics to have one of these purposes.)

Streamlining was necessary because the LLBO was being swamped by applications: nearly 167,000 permits were issued throughout Ontario in the year 1973-74. Since then the totals have been more or less stable from year to year — about 157,500 permits were issued in 1980-81 — perhaps because disposable incomes and alcohol consumption have also been more or less stable.

Odd Little Blip

An odd little blip in the fuzzy line of Ontario's liquor control history took place between 1975 and 1978. On June 5, 1975, the Minister of Consumer and Commercial Relations advised the Legislature of the imminent formation of the Ontario Liquor Advisory Council, described in the press at the time as "a permanent board to advise the Ontario government on its liquor policies." Six months later, when nearly half of the proposed 30-strong Council had been appointed — including representatives of the Canadian Restaurant Association, the Association of Canadian Distillers, the Ontario Imported Wine and Spirit Association, the Ontario Hotel and Motel Association, and the Brewers' Warehousing Company — the minister assigned the Council its first and only task. It was to "study the matter of Special Occasion Permits (SOPs) in the province of Ontario . . . one of the most perplexing and difficult subjects in the whole area of liquor control."

The Council reported in January 1977. One issue dealt with was the "competition of SOPs with licencees." The Council noted that "alcohol consumed under SOPs accounts for 5% of total sales in the province while licencee sales total 10% of consumption," and that "Ontario's licensed premises have invested millions of dollars to provide facilities while SOP holders operate with no capital investment." The report included seven unremarkable recommendations. Concluding remarks emphasized both the value of the Ontario Liquor Advisory Council as a "much needed agency," and "the serious lack of statistical data . . . identified as a critical problem area."

The Council was not asked to take on other tasks before it was disbanded in May 1978.

Policy Advice

A few months earlier, perhaps by coincidence, the Addiction Research Foundation (ARF) had made its first public attempt to influence government policy on alcohol use. In February 1978, a document entitled *A strategy for the prevention of alcohol problems* was prepared for each member of the Ontario legislature. It contained five recommendations, at least one of which would require a change in legislation. The document aroused considerable protest. ARF's action was criticized strongly at the Legislature's Standing Committee on Procedural Affairs: "It seems to me a questionable role for a government agency when it turns from objective research to advocacy," said one member. The Brewers Association of Ontario produced a rebuttal entitled *Ontario deserves something better from the Addiction Research Foundation*, which, with the original document, ARF's response, and further exchanges, was published in full in **The Journal** (June, 1978; April, May, 1979). Meanwhile, the question of *how* alcohol control policy is formulated in Ontario remains as unclear as ever.

Certainly the whole matter of alcohol use in Ontario could do with a good airing. There is much concern about the proliferation of public drinking places, about the increasing toll that alcohol may be exacting on our highways, and about the possibility that teenage drinking may be out of control. On the other hand, a move to public drinking is welcomed by many because it civilizes our cities and because it may be conducive to moderation. Also, alcohol is not seen to be the universal bane it was once imagined to be, because *moderate* use may actually improve people's health.

I don't think a review of alcohol control policies would dwell much on the use of Special Occasion Permits, even though this seemed to be the government's main priority in 1975. Some attention should be given to SOPs, however, because a permit-holder can easily get the impression that their purpose is to encourage drinking rather than to control it.

Bizarre Process

The application forms for Special Occasion Permits are available at liquor stores. A third of the way down the form you come to the difficult part — how much alcohol to purchase. It's important what you enter on the form because that determines both the maximum you can buy for resale at your event and the cost to you of permit fee and levy. The permit fee ($25 to $50, depending on the amount) is not refundable. The levy is refundable on return of unopened bottles. It varies according to bottle size. For regular-sized bottles of liquor and wine it is $1.50 and 75¢ per bottle, respectively, and for a 24-bottle case of beer it is $1.25.

If you haven't worked out how much alcohol you will sell, you may be advised to enter on the form the maximum permitted, or something near it. The maxima, which vary according to anticipated attendance and duration of the event, are truly astonishing. For my last fund-raising event, the inexperienced applicant was advised to put down, for 160 people attending for a 5½-hour duration, 19 bottles of liquor, 30 bottles of wine, and 25 cases of beer. Because getting refunds is a big hassle, there could be a temptation to drink these quantities, which are equivalent to just under nine drinks for each participant. The average person drinking such amounts over a period of 5½ hours would have a blood-alcohol level of close to 150 mg per 100 ml — nearly twice the legal limit for operating an automobile.

It seems bizarre that a process designed to regulate alcohol abuse should encourage the drinking of hazardous amounts of alcohol, or even make it possible. Needless to say, the average consumption at the event in question was much less than the amount permitted; it was just over two drinks per person. We had a lot of unopened bottles to return. The event was successful — we covered half my election debt — but bar profits contributed only a small fraction of the total raised.

Literal Use

Special Occasion Permits seem now to be a device for providing business for the Liquor Control Board of Ontario (LCBO) — which is the government monopoly charged with the retail distribution of most of the beverage alcohol sold in this province — while limiting competition by private functions against bars and restaurants. They seem far removed from their original purpose, as does the LLBO itself. Many would argue that the Board takes the word 'licence' too literally — in the sense of 'licentiousness' — and has strayed too far from the 1927 mandate of the LCBO, from which the LLBO was cleaved in 1944. (For three years it was known as the Liquor Authority Control Board, prior to the 1947 legislation referred to earlier.) The second annual report of the LCBO, for the year ending in October 1928, noted that "the social side of the Board's work has been largely extended," and that progress toward the achievement of "proper results" would only occur with the cooperation of "social workers and others desirous of improving the social conditions of the people."

The LCBO itself seems to have strayed even further from its origins, to the extent that a renaming of the Liquor Marketing Board of Ontario would be in order. Some of the recent trends in alcohol distribution and use are not necessarily bad. My point is that they are controversial, alarming to some people, and worthy of more debate than has been given them. In last month's **The Journal**, Dr Norman Giesbrecht of ARF was reported as calling for the formation of a "high-profile alcohol policy committee" by the Ontario government. I heartily concur.

Next month: A sure way to reduce cigarette use.

FEATURES

Increased services expected

Native alcoholism care 'inadequate'

By Pat Ohlendorf

OTTAWA — Cabinet is this week expected to announce plans to expand Ottawa's programs in alcohol abuse for native Indian and Inuit people.

The federal body is currently deliberating joint recommendations put forward by Minister of Health and Welfare Monique Begin, and Minister of Indian Affairs and Northern Development John Monroe.

The recommendations stem from extensive evaluations of the current federal programs in prevention and non-medical treatment for alcohol abuse for Native people, which began in 1976.

Reflecting one major shift in emphasis is the proposed change in name of the program, from the National Native Alcohol Abuse Program (NNAAP) to the National Native Alcohol and Drug Abuse Program (NNADAP).

"We hope to extend services to reach 100% of the Indians and Inuit eventually," Paul Kyba, the man primarily responsible for drawing up the Cabinet document, told The **Journal**.

At present, there are only seven federal treatment centres for native people across Canada, he said, and only 35% of the Indian and Inuit reserves have prevention programs, which reach only 50% of the population on those reserves.

"We're aiming for an ongoing, permanent program — rather than projects funded year to year — so that alcohol and drug abuse programs can be fully integrated into the communities and linked up with other social services," said Mr Kyba, who reports to the assistant deputy ministers of both health and Indian affairs.

Some changes Mr Kyba hopes to see in the new federal initiative are:

- many more non-medical treatment centres, or residential halfway houses, funded by Ottawa and run by native workers;
- incorporation of drug abuse problems (gasoline sniffing, solvents, glue, sprays, and misuse of prescription drugs) in both prevention and treatment programs;
- more training facilities for native workers in alcohol and drug abuse;
- prevention programs in the schools;
- "action research" into such practical concerns as how to treat cross-addictions and how to mobilize communities to develop and run prevention programs; and
- closer links with other government departments and services, especially those concerned with education, housing, and economic development.

In an interview with The **Journal**, Mr Kyba was unable to describe the recommendations in greater detail because he couldn't "second-guess exactly what the ministers [Begin and Monroe] will recommend and what Cabinet will decide."

But the general areas of need were identified through "a lengthy consultative process with native groups" like the National Indian Brotherhood (NIB), the Inuit Tapirisat of Canada (ITC) and the Native Women's Association of Canada, he said, as well as with representatives from provincial agencies that deal with alcohol and drug abuse.

Present federal services to Indian and Inuit communities are "totally inadequate to meet the needs," Mr Kyba said.

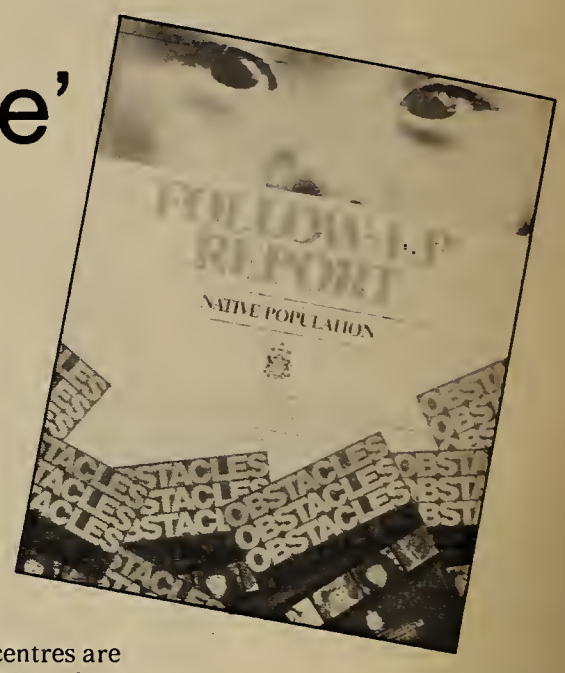
"One problem with NNAAP is that it tried to solve all the problems of the world. It was supposed to reduce alcohol-related crimes, reduce the school drop-out rate, improve the overall social and cultural conditions of Indian people.

"And to do all these great things, a fund of about $3 million was set up. It was an entirely unachievable objective, given those resources and the original time frame of three years."

NNAAP did, however, achieve some short-term goals. It created a "basic infrastructure" through which native people could cope with alcohol problems in their own communities more effectively. The new federal program will use this structure as a basis for expansion.

And experience at the seven federal treatment centres has shown — based on the average length of stay in treatment — that natives respond much better there than in centres not designed specifically for them.

"There's a much greater awareness of the social and cultural factors that relate to native alcohol abuse and rehabilitation in these centres," said Mr Kyba. The centres, residential halfway houses currently located either in cities or on reserves, are staffed by native workers. They provide counselling and rehabilitation for people who have already received medical detoxification.



Alcohol is described as 'the major handicap of native people' in a recent Canadian parliamentary report.

But many more such centres are needed, said Mr Kyba. Also, special treatment strategies must be developed for native women and youth, who are "high risk" groups for drug and alcohol abuse.

The prevention programs, usually consisting of one or two counsellors located in a reserve, currently work with families, coordinate Alcoholics Anonymous (AA) activities, provide referrals to treatment centres, and engage in some community education. But, except for one successful program in New Brunswick, there are no prevention programs in the schools, said Mr Kyba.

"The new federal program will not deal with the root causes of the problem," cautioned Mr Kyba.

"It won't create jobs; it won't create recreational opportunities or improved social conditions."

It should, however, become more integrated with other programs so social planning and budgeting can take alcohol and drug problems into account and the referral network should improve.

Native groups, government officials, academic researchers, and newspaper editors have long recognized alcohol as one of the most serious problems facing native people (The **Journal**, Nov, 1979, Aug, Sept, 1981).

It has been called *the* most serious symptom of the underlying problems of unemployment, lack of opportunities, and the disintegration of social, cultural, and family structures in the face of economic development, environmental change, and clashes with the "dominant culture" of the South.

Ironically, in contrast to most other consumer products in the North, alcohol is in effect government subsidized.

"A quart of milk costs you more in the North than in southern Canada, but a quart of alcohol costs the same," said Mr Kyba.

Mr Kyba, in his present interdepartmental position since last April, formerly served as director of band training and advisory services in the department of Indian affairs.

Airborne quaffers pose potent problems

By Wendy Wright

TORONTO — Pigs in space. It's a term used by flight attendants for inebriated passengers.

About a year ago, Canadian Pacific Airlines (CP Air), followed shortly by Air Canada, introduced a new service for passengers paying full fare. CP's "Empress" and Air Canada's "Connaisseur" offer extras like unlimited "free" liquor.

Most passengers on these flights are business people who don't have the flexibility to book reservations in advance and usually fly on company-paid tickets. The Air Canada traveller from Toronto to Vancouver pays from $168 to $403 more than passengers who book an excursion rate.

When these services began, flight attendants noticed many passengers were stealing liquor. Served small, unopened bottles to pour themselves, they were often given two bottles at a time. The reordering rate made it obvious many passengers were not consuming all their liquor in flight. Large quantities were leaving the plane unopened.

Flight attendants began opening the bottles before serving so if passengers tried walking off the plane with these open bottles in a briefcase, they would either leave a trail of liquor behind them, or their files would absorb the theft.

Some planes now stock large bottles from which individual drinks are poured, but it doesn't solve the problem of passengers who have to be carried off the flight.

Both Air Canada and CP Air agree liquor consumption among the Connaisseur and Empress passengers is higher than excursion travellers who pay per drink. The problem was worse when the service was new.

Mike Dukelow, public relations manager for CP Air, says there was "an education process for both staff and passengers." People abusing the liquor service found they were unable to function when they arrived at their destination.

Flight attendants must deal with those who consume too much. Passengers pay for the service and sometimes resent an attendant who refuses to pour them another drink.

Kerry Collins, of the Canadian Air Line Flight Attendants Association (CALFAA) says many passengers see the liquor services as a perk. The company pays for it. It's theirs to enjoy in lieu of a cash bonus. But, he says, it depends on whether the passenger is travelling to or from work. Does he have business when he disembarks, or is he returning home?

Passengers tend to forget the two-to-one ratio. Because of the altitude, one drink in the air has the effect of two on the ground. Mr Collins has seen some passengers really suffer from this double whammy. He talks of people who leave Toronto at 7 pm, arrive in Calgary at 9 pm Calgary time (11 pm in Toronto), and "can't walk off the plane." Some have been removed by wheelchair.

Pam D'Andreis-Hay is an Air Canada flight attendant and safety chairperson for that airline's CALFAA members. Her impression is that the number of passengers who are getting intoxicated in-flight is decreasing. She suggests this may be because the novelty of free liquor is wearing off, or perhaps, staff has learned how to handle these situations.

The happy drunk doesn't bother Ms D'Andreis-Hay, although he (more often than "she") may be annoying other passengers. The physically-abusive drinker is another story — and fortunately, not a frequent one.

Tipsy passengers pose safety hazards. In the event of an emergency, they might not only endanger their own life, but those of others. Evacuating an inebriated passenger from an accident site delays the process — so pilots and flight attendants have a personal interest in the effect of unlimited liquor service.

Ms D'Andreis-Hay says the Empress and Connaisseur services "won't go away," but she would like to see a limit imposed on the liquor, such as a cocktail before the meal, and wine during the meal.

She would also like more emphasis on educating the public about the effects of liquor at high altitudes, "especially if you have to drive at the other end."

When a drunk passenger leaves the plane and the staff knows there is going to be a problem, the pilot can radio ahead for assistance. There has been the odd case where a passenger has been carried directly to a hotel to "dry out."

Ms D'Andreis-Hay is also concerned about the legal issue. If her crew serves a passenger who becomes inebriated, drives home, and is involved in an accident, "who sues whom?" Air Canada has told her its responsibility "only goes so far" to a drunk passenger. So flight attendants try to impose limits for those passengers who can't do it themselves.

A check with some car rental companies at airport kiosks across Canada does not indicate an increase in "problem passengers" since the unlimited liquor service began. All outlets contacted instruct personnel to refuse to rent to anyone who has liquor on his breath — even if the client has made an advance reservation.

Most rental companies carry their own collision insurance and in the event of an accident don't collect from an insurance company for damages to their vehicle.

Ms D'Andreis-Hay has her own impressions about who is doing the hard drinking. They tend to be expense account-type business people travelling to and from the west, where most of the heavy drinking is done, she says.

Drunk-drive trial fuels Manitoba plan

WINNIPEG — A drunk driver who killed three people while running a red light was sentenced last month by a Manitoba judge to less than three years in prison.

Guy Brian Knockaert, 38, who has never held a driver's licence, has been convicted 15 times for driving impaired or without a licence. He has 30 criminal convictions on his record and received three more last May. Chief County Court Judge Alan Philip convicted him of three counts of criminal negligence causing death, of impaired driving, and of leaving the scene of an accident.

As family members of the victims looked on, Judge Philip sentenced Mr Knockaert to 30 months. (He will be eligible for parole in 10 months.) The maximum sentence for criminal negligence causing death is life imprisonment.

Even as Mr Knockaert's trial was taking place, the Manitoba government was gearing up for an attack on drunk driving. Coincidentally, two days after the conviction and sentencing — and as outraged editorials and letters appeared in the *Winnipeg Free Press* — representatives from the Manitoba department of highways and the Alcoholism Foundation of Manitoba (AFM) met to start a program to re-educate drunk drivers.

Ramsey: gearing up.

"Beginning this spring we will have a program for second (impaired-driving) offenders throughout Manitoba," Ross Ramsey, assistant executive director of the AFM told **The Journal.**

"At the judge's disposition, part of the process of getting a driver's licence back will be coming to the foundation or one of its regional offices."

A pilot project for second offenders in Winnipeg, on which the new province-wide program is based, resulted in 30% of second offenders returning to the foundation for treatment, Mr Ramsey said.

But, he admits, the new program barely scratches the surface.

"What we're most troubled about is that we would like to be doing a lot more than something for second offenders. We would like to have some effect on first offenders. We would like to be doing something that would have a preventative effect, at the time when people are getting their licences."

Discussions between the department of highways and the AFM are continuing, he said. Later stages of the program might include providing information on alcohol, drugs, and driving in driver-education classes.

Manitoba might also consider residential treatment centres for drunk-driving offenders, like the pilot centre underway in Prince Albert, Saskatchewan, he added.

But for people like Guy Brian Knockaert, who never had a licence in the first place, and whom Judge Philip, despite the light sentence, described as probably immune to rehabilitation, the government's efforts may be futile.

The Crown is considering appealing Mr Knockaert's sentence.

Clamps tighter on city-owned property

City takes on alcohol management

By Wendy Wright

TORONTO — Tension over alcohol abuse on civic-owned properties has led the Ontario city of Thunder Bay to introduce a comprehensive policy on alcohol management.

An Addiction Research Foundation (ARF) study shows the percentage of alcohol consumers in Thunder Bay to be greater than the Ontario average. The city, which has direct control over facilities such as community centres, recreation centres, and parks and golf courses, has been faced with constant complaints about people attending alcohol-related functions on civic property.

Until now, City Council has dealt with each complaint on an ad hoc basis, but the complaints have been getting out of hand, and some communities have suggested the closing of establishments where the abuses have been most blatant.

The strategy to handle the problem was worked out by Ronald Douglas of ARF, Sudbury, and Margaret Thomson, a Thunder Bay planner. Mrs Thomson assembled a task team of 10 people with Mr Douglas as technical advisor.

The other members, representing community groups, business, and health and social planning councils, expressed a wide range of opinions about alcohol.

When, where, and how to use alcohol are spelled out in Thunder Bay policy.

Each member had responsibilities for interviewing and polling different segments of the city; the Morality Squad was interviewed to find out what problems it was having with civic facilities. The hotel association was polled to see what effect it would have on their operation if the city installed bars in some civic facilities.

Every suggested policy was assessed for the effect it would have on various groups. And the team came up with a comprehensive policy which was passed by Thunder Bay city council last spring.

The task team also developed guidelines to ensure that licensed functions do not interfere with non-consumers pursuing other recreational activities on civic property.

The policy clearly sets down when and where special occasion permits for the sale of alcohol, or consumption without sale, will be granted. How alcohol-related functions are to be run is also spelled out. Supervisors are now required at all functions where alcohol is served, and are legally accountable for any mishaps.

Supervisors are either volunteers trained by the city, or hired security officers.

Mr Douglas says it is not the alcoholic who is of concern but the social drinker who associates drinking with leisure activities — then goes too far.

Recreation professionals are now starting to worry about the associated damage to property and risks to health and safety. A Quebec fire in which many people died points out the legal liabilities; civic suits resulting from the fire were filed against the owner of the hall, the sponsor of the party, and a number of other people.

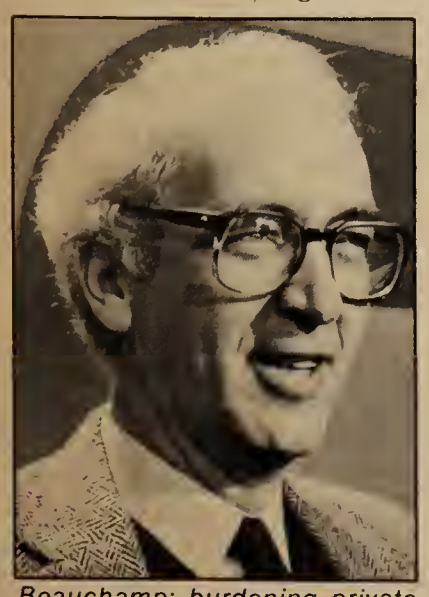
Health policies aim at the aggregate

'Individual harm is often minimal'

By Pat Ohlendorf

TORONTO — Most people drink far less alcohol than would be hazardous to their health," says Dan Beauchamp of the School of Public Health at the University of North Carolina.

"But the rules of alcohol use in most societies are a conservative set of rules that discourage alcohol use. This may not benefit specific individuals but will benefit the general good of society."



Beauchamp: burdening private activity for general good.

Speaking to a group of Canadian professionals and students at the Addiction Research Foundation of Ontario (ARF) here, Dr Beauchamp said: "It's not too much government interference that worries me. I'm worried about the *indifference* of the government in the United States to the health of its citizens, under the banner of individual freedom."

This stance has prevailed, Dr Beauchamp said, in both the Reagan and Carter administrations.

Instead, Dr Beauchamp recommended, government should create certain restrictions on individual liberties for the larger public good. But these limits should be reasonable, applying only to those activities which are significant public health problems.

"Invoking 'the public good' whenever the government pleases can lead to a repressive regime such as now exists in Poland," said Dr Beauchamp in response to a question.

Thus, government should concern itself with problems like drunken driving and smoking, and should "forget about rodeos."

According to Dr Beauchamp, many people believe the only reason governments should limit individual activities is to prevent harm to others. This idea stems from the political philosophy of John Stuart Mill and is "very different from what motivates government restrictions in the US and Canada."

On the basis of this belief, he continued, many people criticize as paternalistic such things as municipal fluoridation of water, mandatory seat-belt laws, anti-smoking regulations, and mandatory helmets for motorcyclists.

Time and time again courts in the US have upheld so-called 'paternalistic' laws.

Rejecting the argument that "fluoridation is an improper use of government power because tooth decay is not a communicable disease," several state courts have declared that in this situation the rights of the individual must give way to the common public-health good.

Similarly, legislation requiring motorcyclists to wear helmets has been upheld on the basis that motorcyclists without helmets who are in serious accidents might become wards of the state.

The landmark case establishing the right of the government to restrict individual liberties for the larger, public good is Jackson vs Massachusetts. When smallpox innoculations were declared mandatory in 1902, a Mr Jackson argued that he alone should have the right to govern his own body and that submitting to an innoculation was an infringement of his personal liberty.

All the courts, including the US Supreme Court, said Dr Beauchamp, rejected Mr Jacobson's appeal — not because Mr Jacobson would have been a threat to public health by not having an innoculation, but because his refusal to conform undermined a law designed for the good of society.

"Many health risks are *very* acceptable at the individual level," he continued. "This is something public-health officials don't like to talk about. We want people to fear the consequences of lighting a cigarette, not putting on a seat belt, or having a drink." But the chances of causing harm to oneself are either minimal or far in the future.

"Public control policies," said Dr Beauchamp are aimed at the economic and social domains. Government control in the area of health does not really promote the welfare of the individual but aims at the aggregate society.

"You burden private activity in order to produce a general good. The public good is produced by the participation of individuals, who must remember that they are part of a very large group."

Teen stress is focus of trustee plan

TORONTO — The Canadian School Trustees' Association has kicked off a $1.2 million fund-raising campaign to finance a charitable foundation aimed at helping youth cope with the problems of stress.

At a press conference here, Rubymay Parrott, president of the new Youth Stress Jeunesse Project described today's youth as a "frustrated, insecure group of people who are desperately in need of direction." Mrs Parrott is also president of the Canadian School Trustees' Association.

Citing statistics that show an escalating rate of alcohol and drug addiction among young people, Mrs Parrott emphasized the need to educate the young on the problems of "negative stress" and "stress overload."

"If we are unable to harness stress," says Mrs Parrot, ". . . it can open up emotional vulnerabilities and cause us to turn to defence mechanisms, such as drugs, alcohol, and tobacco, to help us cope."

The Youth Stress Jeunesse project intends to create a national crisis centre, operating on a seven-day, 24-hour basis, staffed by volunteers trained by the Selye Foundation. Dr Hans Selye, a leading name in stress research, is an honorary patron of the project.

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Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

The last hurrah

Protest can be healthy

I read with interest the features on alcohol problems in the North (**The Journal**, Aug, Sept 1981).

In the article, A Tale of Two Cities, the objections of the citizenry of the Yukon to new laws were discussed. It was mentioned that two years ago public drinking was banned in the city of Whitehorse.

It was also mentioned that the night before the ban went into effect, a public drinking party was held where rowdiness and bottle throwing took place. This was clearly a form of protest and, on the surface, seems to be regrettable.

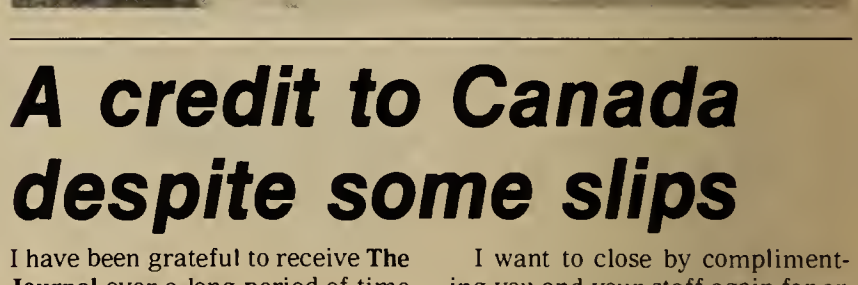
However, an alternate view is that this was a hopeful sign — the fact the event took place the day *before* the law went into effect suggests the participants were acknowledging their behavior would be different in the future. They were not flouting the new law.

One of the things I am becoming increasingly aware of is that despite concern about liberties lost with legal approaches to prevention of various kinds of problems, people do rely heavily on the law to protect them from harm in their environments. There is a recognition that legal restrictions constitute a form of education in themselves. When such legislation and its enforcement is not generally seen to be an extreme affront to civil liberties, as with the Whitehorse ban on public drinking and the seat belt legislation in Ontario, after an initial protest, people are generally accepting of the laws.

The protest may be healthy. It shows that those affected are paying attention to the change.

Lynn Wolff
Consultant
Addiction Research Foundation
Kitchener, Ont

THE TRUE NORTH



A credit to Canada despite some slips

I have been grateful to receive **The Journal** over a long period of time at no cost to me.

I would like to compliment you on the factual reporting and objective viewpoints on the various addictions.

I have received invaluable information from **The Journa**l which has heen of great benefit to me personally as a recovered alcoholic and in terms of my continuing interest in the field of addictions as it applies to the Kenora District.

There are times when I think that some of the data and information have been supplied by a lunatic and, while the intentions might be excellent, the input is far from reality. However, I try to keep an open mind and one that is free from prejudice. I suppose that what I see as irresponsible statements might be factual data to others.

I do have the advantage of personal experience with the problem of alcohol since about 1947, and I have learned the hard way, over the years, some of the answers to the increasing problems of the use of chemicals, whether they are swallowed, chewed, injected, or sniffed.

I want to close by complimenting you and your staff again for an excellent publication which has received world recognition and is a credit to the Province of Ontario and to Canada.

Best wishes in your future endeavors.

C.R. Scott
Kenora, Ont

Minorities of interest

We greatly enjoy receiving **The Journal**. It's very comprehensive, especially about United States drug policy. Would like to see more emphasis on drug concerns to equal emphasis on alcohol issues — would prefer a substance abuse focus.

Our emphasis is on ethnic minority groups in the US and as such we are interested in your articles on the native population in Kenora, for example, and would like to see more about minority groups described in **The Journal**. We would be happy to provide any information desired.

C. Maymi
Arlington, VA

AA myths continue

Alcoholics Anonymous needs no defence from me or anyone else. The record speaks for itself. However, from time to time, there is a need to dispel myths and, as a longtime member, I feel obliged to do that.

The case in point is Alan Massam's excellent article on EAPs (**The Journal**, Jan) where reference is made to "hitting bottom." The fact of the matter is that the "confrontation with the supervisor" can *be* the "bottom" for some people, while unfortunately others have to seek a much lower level of crisis before they will admit to having a problem.

The history of AA sparkles with stories of people who, very early in their alcoholism, have been confronted with a rather minor crisis, sought help, and now live productive lives.

Surely, any AA member would be glad to explain "Hitting Bottom" to Alan Massam or anyone interested.

Keep up the good work, we think **The Journal** is tops.

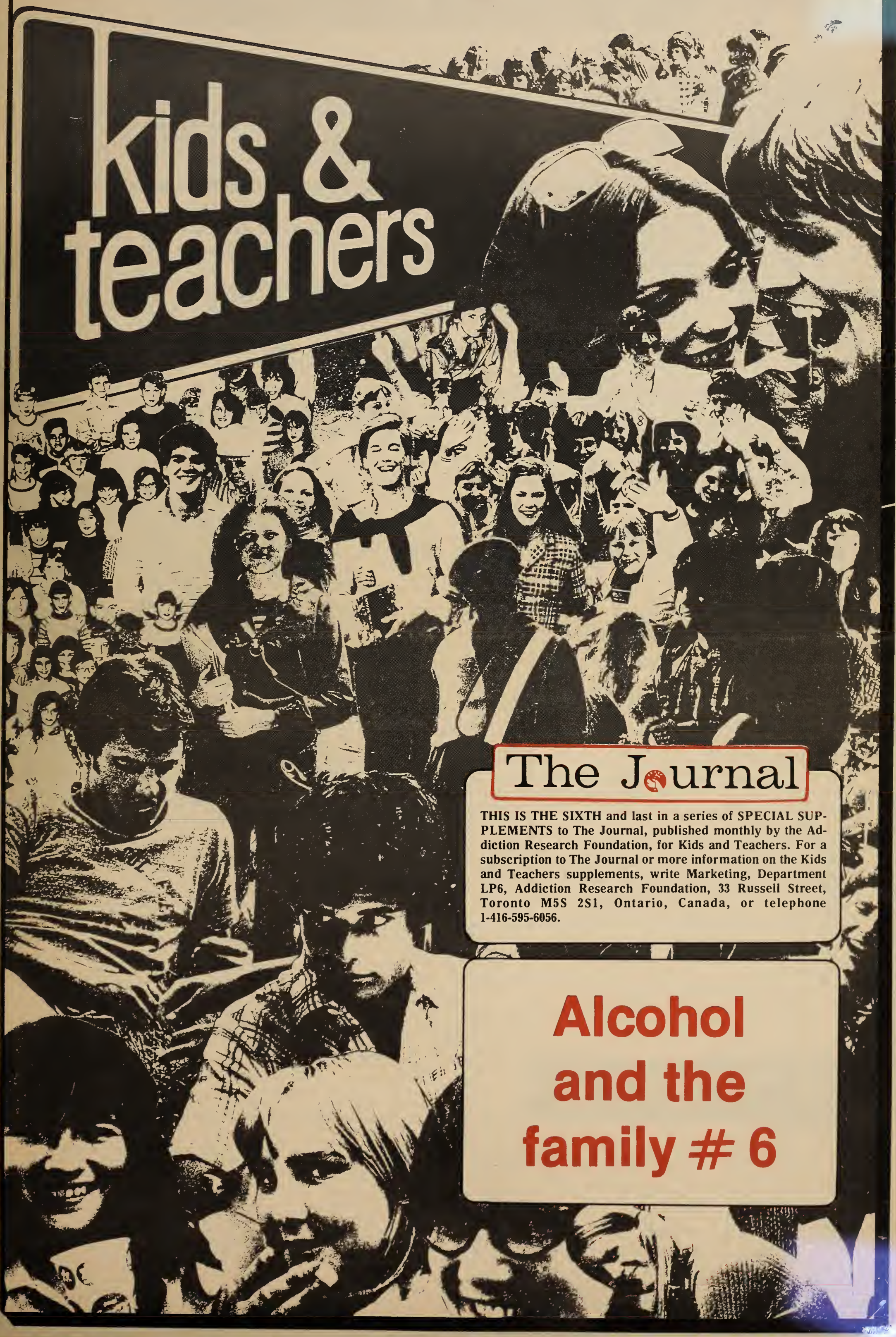
Al M.
Box 554
Sydney, NS

TJ 'subtle'

The Journal continues to present an excellent and subtle range of articles.

Michael O. Smith, MD
New York, NY

kids & teachers



The Journal

THIS IS THE SIXTH and last in a series of SPECIAL SUPPLEMENTS to The Journal, published monthly by the Addiction Research Foundation, for Kids and Teachers. For a subscription to The Journal or more information on the Kids and Teachers supplements, write Marketing, Department LP6, Addiction Research Foundation, 33 Russell Street, Toronto M5S 2S1, Ontario, Canada, or telephone 1-416-595-6056.

Alcohol and the family # 6

kids & teachers

YOU ASKED US. . .

Dear Karen,
I thought the legal drinking age in Canada was 19 years old. When I went to Montreal this summer, I found the age is only 18 there. Why? — **Age 18**

Dear Age 18,
You'll find you may drink legally at 18 in some other provinces too. Legal drinking ages are set by each provincial government, not the federal government. I know this is confusing because some laws related to alcohol are controlled by the federal government; for example, the drinking/driving laws. However, others (eg laws about drinking in a public place) are under provincial control. The legal drinking ages by province are: Newfoundland, 19; Nova Scotia, 19; Prince Edward Island, 18; New Brunswick, 19; Quebec, 18; Ontario, 19: Manitoba, 18; Saskatchewan, 19; Alberta, 18; British Columbia, 19; Northwest Territories, 19; and Yukon Territory, 19.

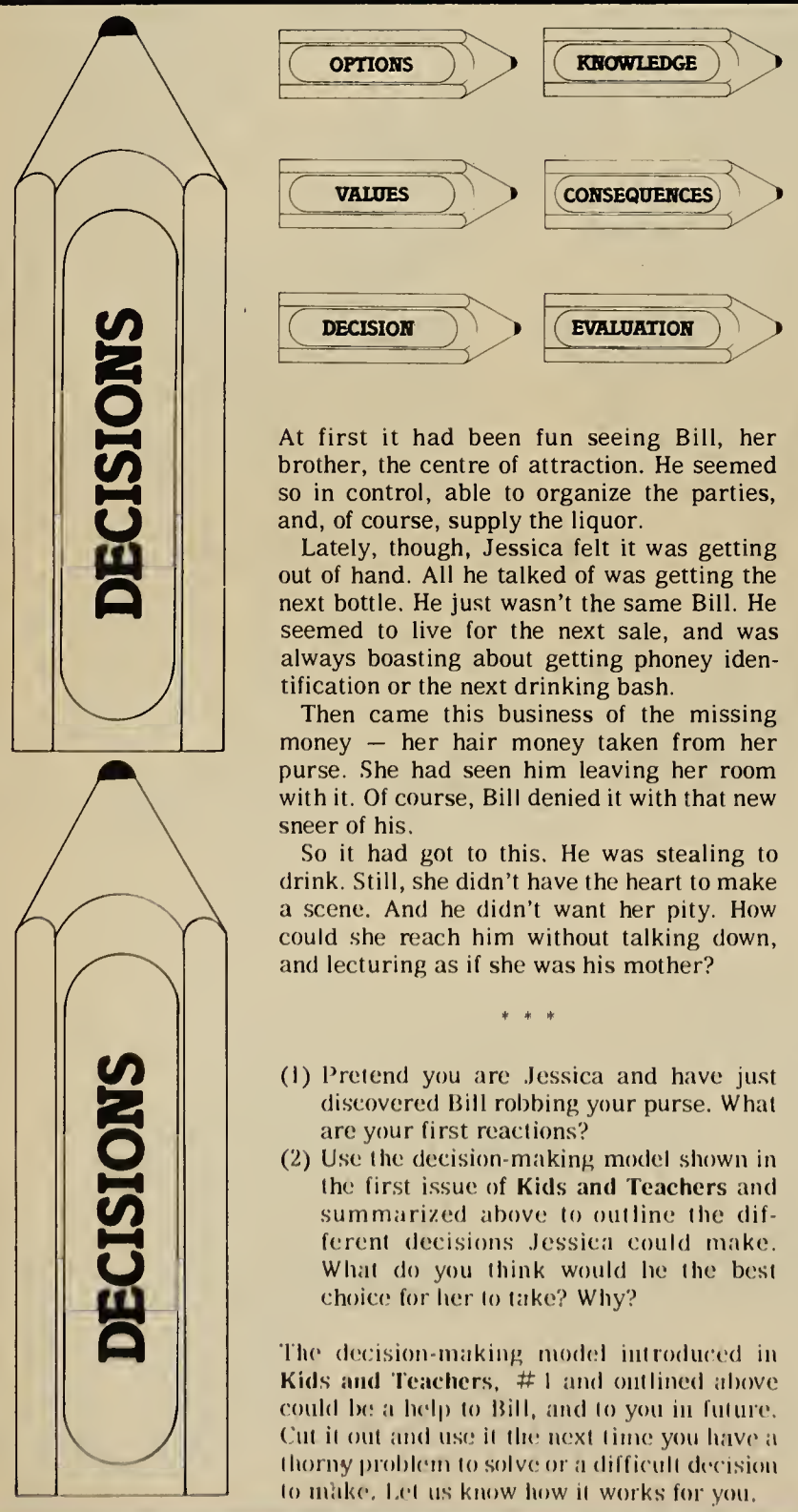
Dear Karen,
I'm four months pregnant and have decided to keep my baby. I see my doctor regularly and want to keep as healthy as possible. My doctor suggested I not drink alcohol or coffee, or smoke, while I'm pregnant. I don't smoke anyway. His nurse said not to use any "over-the-counter drugs," either. What did she mean by this? — **Mother-to-be**

Dear Mother-to-be,
I would suggest you double-check and ask the nurse to explain what she meant. The term "over-the-counter drugs" means ones available without a prescription. As you know, you should ask your doctor about every kind of medication you plan to use. If your doctor agrees to your taking certain kinds of non-prescription or over-the-counter medication during your pregnancy, read and follow the label directions carefully. You could also ask your pharmacist for information on prescription and non-prescription drugs.

You should consult your doctor and/or pharmacist if you plan to take analgesics (pain tablets), antacids, antidiarrheals, antiemetics (antinauseants), caffeine, cold remedies, antihistamines, laxatives, or vitamins. Many products, if taken during pregnancy, may affect the future health of the baby.

You sound quite well-informed and concerned about your health and that of your baby. Good for both of you.

Is there something you want to know about drugs? Karen Girling answers a lot of questions from students and teachers in her job as information specialist at the Addiction Research Foundation. Why not ask her? Write Karen, c/o *Kids and Teachers*, The Journal, Addiction Research Foundation, 33 Russell St., Toronto, M5S 2S1 Ontario, Canada. Names will be withheld.



At first it had been fun seeing Bill, her brother, the centre of attraction. He seemed so in control, able to organize the parties, and, of course, supply the liquor.

Lately, though, Jessica felt it was getting out of hand. All he talked of was getting the next bottle. He just wasn't the same Bill. He seemed to live for the next sale, and was always boasting about getting phoney identification or the next drinking bash.

Then came this business of the missing money — her hair money taken from her purse. She had seen him leaving her room with it. Of course, Bill denied it with that new sneer of his.

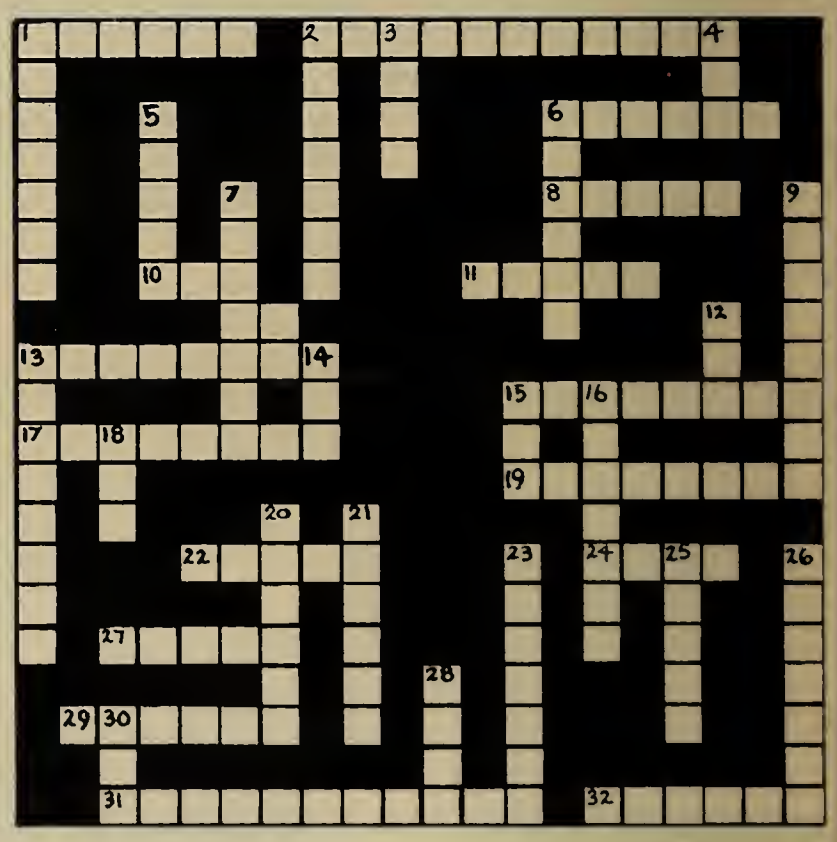
So it had got to this. He was stealing to drink. Still, she didn't have the heart to make a scene. And he didn't want her pity. How could she reach him without talking down, and lecturing as if she was his mother?

* * *

(1) Pretend you are Jessica and have just discovered Bill robbing your purse. What are your first reactions?
(2) Use the decision-making model shown in the first issue of **Kids and Teachers** and summarized above to outline the different decisions Jessica could make. What do you think would he the best choice for her to take? Why?

The decision-making model introduced in **Kids and Teachers**, # 1 and outlined above could be a help to Bill, and to you in future. Cut it out and use it the next time you have a thorny problem to solve or a difficult decision to make. Let us know how it works for you.

CROSSWORD



Across
1. Self-help group for husbands and wives of problem drinkers (6)
2. A type of sedative drug, sometimes called a "barb" (11)
6. Tranquil or calm (6)
8. Drug that comes from a kind of poppy (5)
10. Narcotic Control Act (abbreviation) (3)
11. Amphetamine (slang) (5)
13. _____ Control Act (8)
15. An easygoing, friendly person who enjoys the company of others is a _____ person (8)
17. A popular name for a bedtime drink for adults (8)
19. Response (8)
22. Act again (5)
24. Lazy (4)
27. Blood alcohol _____ (5)
29. Group of closely related people (6)
31. Drugs that kill certain types of bacteria (11)
32. Causing death (6)

Down
1. Self-help group for teenage children of problem drinkers (7)
2. More than four drinks may make your vision _____ (7)
3. Rhymes with whisk (4)
4. French for "is" (3)
5. Usual color of hashish (5)
6. Person who smokes (6)
7. Disorderly (7)
9. Legal drinking age in Quebec (8)
12. Taxi (3)
13. Legal drinking age in British Columbia (8)
14. Policeman (slang) (3)
15. Term of respect for a man (3)
16. Strong desire for something (7)
18. Fuel for most cars (3)
20. Grain used to make some beers (6)
21. Road (6)
23. When you're embarrassed, your face _____ (7)
25. The speed _____ is 100 km/h on many highways (5)
26. Liquor (7)
28. Against, as in _____ -war (4)
30. Acetylsalicylic acid (abbreviation) (3)

Down
1. ALATEEN, 2. BLURRED, 3. RISK, 4. EST, 5. BROWN, 6. SMOKER, 7. CHAOTIC, 9. EIGHTEEN, 12. CAB, 13. NINETEEN, 14. COP, 15. SIR, 16. CRAVING, 18. GAS, 20. BARLEY, 21. STREET, 23. BLUSHES, 25. LIMIT, 26. ALCOHOL, 28. ANTI, 30. ASA.

Across
1. ALANON, 2. BARBITURATE, 6. SEDATE, 8. OPIUM, 10. NCA, 11. SPEED, 13. NARCOTIC, 15. SOCIABLE, 17. NIGHTCAP, 19. REACTION, 22. REACT, 24. IDLE, 27. LEVEL, 29. FAMILY, 31. ANTIBIOTICS, 32. LETHAL.

THE KIDS ON HIGH ST.

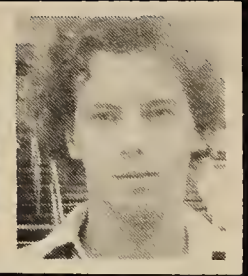
featuring Al Ked

. . . WE ASKED YOU

kids & teachers

How would you feel if you saw someone drunk who you never before imagined would get drunk? How do you think this person may have affected his or her family?

Mary and Brent have been asking other teenagers questions each month for Kids and Teachers. If you have a question you'd like Mary and Brent to ask, send it to them at: Kids and Teachers, c/o The Journal, 33 Russell St, Toronto M5S 2S1, Ontario.



Nicole, 14:
I would be surprised but I wouldn't think less of the person because everyone is entitled to a few mistakes. The family might be disappointed in the person. However, they would not lose any stature provided this is an occasional occurrence.

Camille, 12:
I wouldn't feel too great because if I look up to them, I would think they wouldn't do something like that. I would ask them why they were drunk and if it was a good answer I wouldn't be too mad. I think this person would make a bad impression on his or her children because the kids probably look up to their parents just as much as I do.

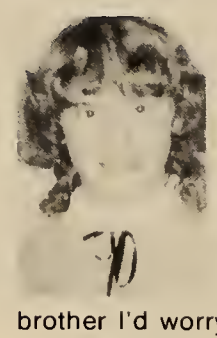
Bill, 13:
I would feel shocked to see that person drunk. I'd feel as if I had been let down by a good friend. The effect on the children in the family would probably be harsh as well. They might not care about their school marks, or they might pick on other kids at school. They might get drunk themselves because they feel no one cares for them, so why should they care for others?

Stephanie, 12:
I would feel upset because you would think that person had better control of him or herself. This person would affect his or her family because they would have a bad influence on their children.

Lisa, 12:
I feel I should stay away from them. I'm uncomfortable and afraid and feel ashamed of them. This happened to a relative when my younger brother was there too, and he shouldn't have gotten drunk in front of us. It didn't really affect anyone, though. His children are grownup and he doesn't get drunk a lot.

Hendrik, 13:
I would think "oh, my gosh." I would try to tell them not to do this. I once asked a family friend to stop smoking and he did it, for a Christmas present, so it might work with a drinking person. The family probably would be thinking they'd rather have someone who's not drunk in the family.

Doug, 14:
I usually ignore it. I'd try to stay away from them because they might puke all over me, or get clumsy. The family would try to hustle them home so nobody would see them. They'd probably be ashamed.



Jennifer, 12:
I've never seen anybody in the family drunk — just on the streets. If it happened I think I'd be sort of scared; if it was my brother I'd worry what my dad might do to him. I would stay away from whomever it was, for different reasons. I have a relative who drinks a lot, but he never gets drunk. If he did, I think his kids might be scared of him; they're quite small. But they're not scared when he drinks normally.

Did you know?

- Family adjustment to a drinking problem is usually accompanied by anger, tension, and resentment.
- An alcohol problem takes a long time to develop. It will not be resolved overnight.
- Involving a whole family in treatment not only helps the alcoholic but assists other family members in dealing with their own conflicts, anxieties, fears, and confusion.
- A common belief is that once the drinking stops, all family problems disappear. On the contrary, attaining sobriety is only one step in that direction.
- Ontario has more young drinkers than any other province in Canada.

ASK YOURSELF

Stuck With Drinking?

There are times when other people expect you to drink. Sometimes it just doesn't seem possible to say no.

Have you ever found yourself in any of these sticky situations?

1. Your friend's 22-year-old brother has bought some beer for your Friday night get-together. The three of you have met to "tie one on." You're starting to have second thoughts as you chug your second beer, but you don't want to lose your friends.
2. At a family wedding reception, a relative decides it's time for you to "learn to drink." Without your parents' knowing it, you've had three drinks and are on your fourth. You're feeling dizzy, and here comes your relative with another drink.
3. You've been invited to a friend's house for dinner. Everyone in this family always has several glasses of wine with a meal. You might appear rude if you don't follow their customs.
4. You're the youngest in your group of friends.They all drink — they're over the legal drinking age, but you're not. You know you'll be expected to drink at their graduation dinner and dance tonight.
5. You're at a football game and have already had quite a bit to drink. The crowd is getting rowdy, and your friends are pushing you to keep drinking.

What would **you** do in these situations?

1. _____
2. _____
3. _____
4. _____
5. _____

What situations have you been in where people have expected you to drink?

_____
_____
_____
_____

How did you handle those situations?

_____
_____
_____
_____

Were you satisfied with how things turned out?

_____
_____
_____
_____

Now, check out possible solutions to these problems (below), and compare them with your solutions.

Here are some possible solutions:

1. Maybe it's time to make your exit. You could offer reasons such as "I have to get up early to work (or for a game) tomorrow;" "I'm taking medication that doesn't seem to mix too well with this beer;" or "This doesn't taste so good — count me out. I'll call you both tomorrow." (And be sure you *do* call them).
2. There are times you just have to look someone squarely in the eye and say no. If your relative persists, approach your parents with the problem. They'll likely support you in your not wanting to drink. Don't worry about insulting your relative — this person's judgement is obviously out-to-lunch today.
3. Speak to your friend ahead of time and ask if you could have either another beverage or an additional one (water, soda, pop etc.) Accept the wine graciously, sip it, and drink the other beverage as a thirst-quencher. As long as your wine glass is full, it won't be refilled.
4. When it's your turn to order, request a non-alcoholic drink with the same confidence and nonchalance as your friends have when they order their drinks. Decide ahead of time what you'll order. If you like, practise saying it convincingly ("Soda with a twist of lime, please.") If wine is served with the meal, turn it down graciously.
5. Maybe it's time to make your exit here, too. If you don't want to leave by yourself, ask a friend to go with you. You could say simply "I'm off; see you later," or "I want to go see so-and-so; catch you on Monday."

kids & teachers

Teacher Objective
To discuss alcohol use and abuse in the family and learn how to get help if it's needed.

Student Objective
To understand that alcohol abuse can create problems in a family and that help is available.

ALCOHOL AND THE FAMILY

Step 1
To introduce the topic of the possible effects of alcohol on the family, use any one of the following resources:
Films: (available free of charge in Ontario from the library, Addiction Research Foundation)
1. The Summer We Moved to Elm Street
2. If You Loved Me
3. Francesca, Baby
Books:
1. *Francesca, Baby,* Joan Oppenheimer
2. *The Secret Everyone Knows,* Cathleen Brooks
3. *Sarah T., Portrait of a Teen-age Alcoholic,* Robin Wagner

Step 2
Ask students to list individually one or two good things about family life; eg support, companionship, and the feeling that you can depend on someone. Have them form small groups to compare lists of good things about families to see what qualities are most liked. Ask groups to put together characteristics of an "ideal family."

Characteristics of an ideal family probably include:
— talking openly and honestly
— resolving conflicts through discussion and compromise
— enjoying some activities together
— having respect for one another's individuality

Ask groups to share their ideas about ideal families but to recognize that no family is ideal — there are always some problems in any family.

Step 3
Below is an excerpt from a book called *The Forgotten Children.* The two speakers are Sally, a 14-year-old whose father is an alcoholic, and Margaret Cork, a social worker and author of the book. At the end of the excerpt are some questions about how alcohol affected Sally's family.

People:
A member of Alateen or Alanon.

If none of these is available, ask students to read the excerpt from *The Forgotten Children* (Step 3 on this page) as an introduction.

Sally was a 14-year-old daughter in a family of five children. Although the father's earning capacity was high, the children were all rather poorly dressed. Sally had a particularly neglected appearance and very poor posture. Her face seemed strained and her expression lifeless.

Sally began by saying, "*I am always sad, not just because my father drinks but because of the way he is.*" Then she burst into tears. When she had pulled herself together, she added somewhat bitterly, "*He's always getting mad and smashing things.*"
"What does your mother do?" asked the social worker.

"*She yells and nags. She's always nagging, but he drinks and acts like that anyway. Anything can start him off but mostly it's mom. Pretty soon he's yelling at all of us. He never wants to eat with us — just lies around and moans and groans, saying how awful he feels.*"

"How does this make you feel?"

"*I keep wishing he'd just drink like other people. But the nagging and the fighting are worse than the alcohol. He hits mom sometimes.*"

"Do you ever tell your father how you feel?"

"*No.*"

"Why not?"

"*He'd hurt you — say mean things. You just can't talk to him about anything that matters.*"

"How do you feel about the way your mother and father get along?"

"*I love him, but sometimes I think mom asks for it. She gets him going until he starts to drink.*"

"Do they ever do things together, such as going out with friends or bowling?"

"*Sometimes mom goes out to dinner with dad, but mostly he doesn't ask her. If she goes, I think she does it just to see that he doesn't drink too much. She never acts as though they had a good time.*"

"Does your mother do things by herself, like visiting with neighbors or friends?"

"*No, she never talks to the neighbors and hasn't any friends.*"

"Does your father help your mother around the house?"

"*No, he's always sleeping it off or fighting. Mom has to do everything, or else we try to do it. There's never any time for fun.*"

"Do your mother and father ever make plans for holidays or special occasions?"

"*Never. They just argue. Things just happen in our house. You never know what's what.*"

"Do you ever talk to your mother about how you feel?"

"*You can't talk to her because she doesn't pay any attention to you. She just worries about dad.*"

"Tell me about your friends. Do they know how things are?"

"*No, I never bring them around when mom and dad are fighting. When I do bring friends in, he's always so nice to them they think he's swell. He's nice to everyone but his family.*"

After a pause Sally added, "*I feel different from other kids. Of course, we might be more like other families if dad didn't throw his money away. We could have things and do things like other kids. I know dad really could afford to send me to university, but when the time comes I suppose he won't have the money. Anyway, I'd never be able to concentrate enough.*"

How were the following issues affected by alcohol use in Sally's family?

a. money
b. arguments
c. outside activities
d. affection among family members
e. guilt in family members
f. family relationships: how each family member reacts to the drinker, how the drinker reacts to each family member
g. plans for the future

Step 4
Ask: What can be done by members of families such as Sally's in which alcohol seems to be causing problems? Discuss from the viewpoint of each family member. Have copies of Alanon and Alateen literature available for students to use as reference.

If someone in your family has an alcohol or drug problem, here are some tips for both parents and kids to follow:

- find support from friends or from other family members
- be supportive without covering up
- don't nag or create quarrels
- make sure the person with the problem knows about Alcoholics Anonymous or other self-help organizations for drug abusers, but don't nag him/her about joining — this has to be a personal decision
- pick appropriate times for discussions about problems
- consider joining Alanon, a self-help group for husbands and wives of problem drinkers, or Alateen, a self-help group for teenage children of problem drinkers.

Step 5
A person caught up in a family where there are alcohol or other drug problems has to live his/her own life without covering up for, taking blame for, or feeling guilty about the problem drinker. If these negative feelings become overwhelming, and they often do, there are people and groups to help.

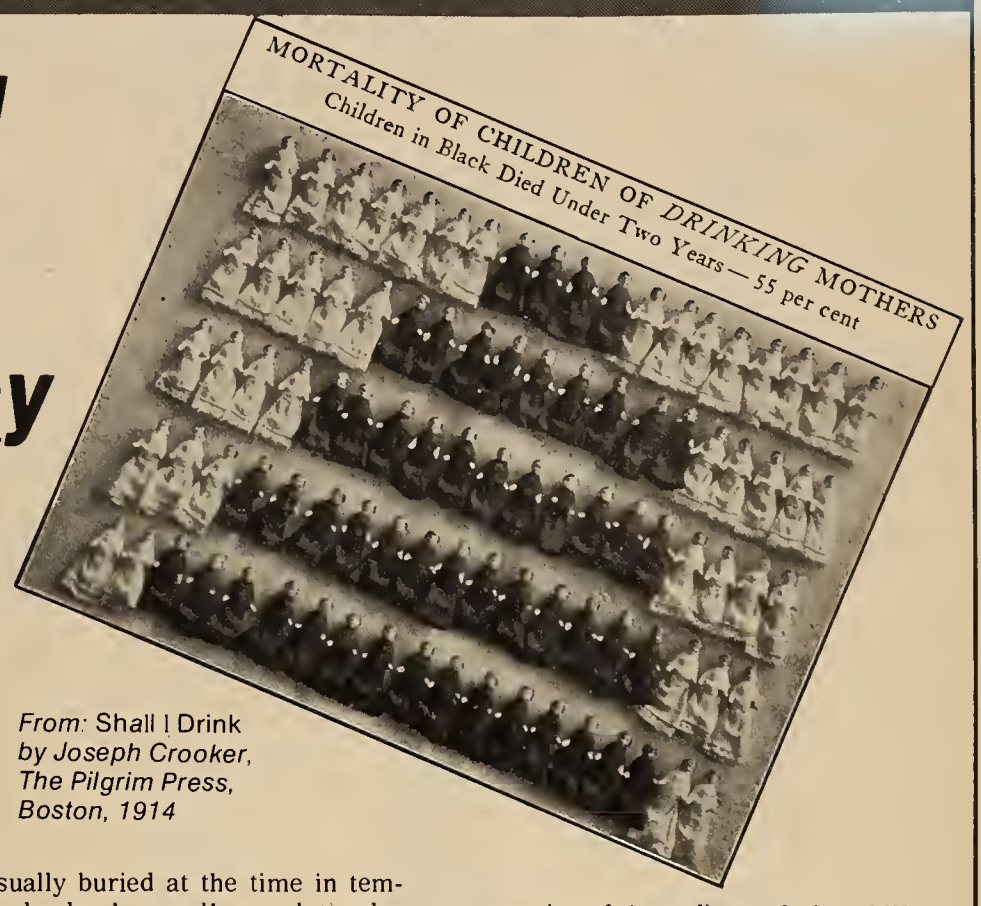
Now you know — if this ever becomes a problem in your life.

Our Mistake

The February issue of Kids and Teachers *contained a common error. Legally a person is intoxicated when the blood alcohol level is* above *0.08% (not "0.08% or higher" as we stated.)*

Editorial team: Anne MacLennan, editor; Greg Arbuthnot, design; Evelyn Cluer, cartoons and crossword; Jerrime Craig, production; Susan Lawrence, editorial consultant; Sharon MacLennan, graphics; Marg Sheppard, education consultant. Columns by Paul C. Brown, Karen Girling, Brent Poulton, and Mary Schankula.

Plato's thoughts recalled in 1980s research on alcohol and pregnancy



From: Shall I Drink *by Joseph Crooker, The Pilgrim Press, Boston, 1914*

By Lucy Barry Robe*

Fetal alcohol syndrome is a recent medical term. But the potential danger of drinking alcohol during pregnancy is rooted in history. For at least 2,300 years, eminent people have warned women that alcohol and pregnancy don't mix.

In *Laws of Plato* (translated by Thomas P. Lange for Basic Books in 1980) the great philosopher, who lived from 428-347 BC, suggested that night-time drinking should be barred to "any man or woman who was intending to create children."

"It's quite hard to tell just what night or day," Plato continued, "the child will be conceived . . . children shouldn't be made in bodies saturated with drunkenness. What is growing in the mother should be compact, well attached, and calm."

He warned that "a drunk . . . is likely to beget, at such a time, offspring who are irregular, untrustworthy, and not at all straight in character or body," and that drink would "stamp these effects on the souls and bodies of embryos, and create children who are in every way inferior."

Aristotle observed in his *Problemata* that "drunken and harebrained women" were likely to have children like themselves, "morose and languid."

Newlywed couples in both ancient Carthage and Sparta were forbidden by law to drink alcohol, for fear of producing defective children.

The *Bible* (Judges: 13:7 (Oxford Edition)) describes an angel talking to Samson's mother about her impending pregnancy: "From this time onwards, drink no wine or strong drink."

The Babylonian *Talmud* (Kethuboth 32b) written sometime between 200 and 500 AD, warned pregnant women: "One who drinks intoxicating liquor will have ungainly children."

In Colonial times, the United States had a "reputed 100,000 female drunkards," said W. J. Rorabaugh in *The Alcoholic Republic*. Doctors used alcohol as a drug; 18th century midwives used gin to ease the pain of labor.

When England lifted her traditional restrictions on distillation, cheap gin flooded that country, creating the famous "gin epidemic." Birth rates dropped, death rates of young children rose, and by 1726, the College of Physicians was alarmed enough to petition parliament for control of the distilling trade, saying that parental drinking was "a cause of weak, feeble, and distempered children."

Gin Lane, *an engraving by Hogarth (The Bettmann Archives, New York).*

Despite these warning from England, alcohol remained a popular cure for "breeding sickness" in America.

In 1787, Dr Benjamin Rush, *Declaration of Independence* signer and the first English-speaking physician to propose that alcoholism was a disease, warned against prescribing alcohol to pregnant women. He said this could produce dependence on alcohol in children — a theory again under serious consideration by researchers nearly 200 years later.

Throughout the 19th century, scientific journals reported high frequency of mental retardation, epilepsy, stillbirths, and infant deaths among children of alcoholic parents. These accounts were used by temperance leaders to further their cause. In addition, "well-educated physicians in the 19th century discouraged the use of alcohol during pregnancy," says Sarah E. Williams in a 1980 *Journal of Studies on Alcohol* article.

A 19th-century patent medicine, Lydia E. Pinkham's Vegetable Compound contained 19% alcohol. It offered cures for sterility, morning sickness, and labor pains.

Even for avid temperance crusaders, however, alcohol was accessible. Women suffered from a kaleidoscope of stereotyped female complaints, which doctors dodged treating. Patent medicines, with alcohol contents ranging from 6% to 50% (that's 12 to 100 proof) jumped into the breach. Sold over the counter, these bitters, tonics, and compounds promised relief from every female complaint their promoters could dream up.

A *Ladies Home Journal* survey in the late 1800s showed that three-quarters of a group of WCTU (Women's Christian Temperance Union) crusaders used patent medicines.

The most famous medicine was Lydia E. Pinkham's Vegetable Compound, first marketed in 1875, which was 19% alcohol (38 proof). Stronger than table wine or sherry, the recommended dose was "one tablespoon every four hours throughout the day."

Pinkham's, which sold briskly until the 1930s, offered cures for sterility ("A Baby in Every Bottle"), morning sickness, and labor pains.

"Every 20-ounce bottle" (of Hotstetter's Stomach Bitters) said W. H. Daniels in his book *The Temperance Reform* (1878), "contains the same amount of alcohol as a pint of pure whisky." Hotstetter's *was* 86 proof, but important facts such as these were usually buried at the time in temperance leaders' overall moral tirades against the evils of drink.

In its 1897 catalogue, Sears, Roebuck and Co advertised 24-ounce "Peptonic Stomach Bitters" as "an excellent appetizer . . . a wineglassful taken before meals will give you an appetite and a satisfied feeling and enable you to enjoy what you eat and digest it well."

Two, weekly, 20-ounce bottles of strong bitters yielded about 28 bar shots (at one oz each) — the equivalent of four drinks of hard liquor every single day.

In 1899, William C. Sullivan, physician to a Liverpool prison, published what was apparently the first careful study of babies of alcoholic women. Comparing them with children of their non-alcoholic relatives, he found that infant death and still birth rate was 2½ times higher in the alcoholics' children. Dr Sullivan also noted that several alcoholic mothers, when they couldn't drink during pregnancy because they were in jail, bore healthy infants even though they had previously produced babies with severe and often fatal complications.

"We are not dealing with degenerate and exhausted stocks," he said in *Medical Temperance Review* in 1900, "in which the role of alcoholism is merely to hasten an inevitable and desirable extinction."

In 1903, L. G. Robinovitch wrote on "Infantile Alcoholism" in *Quarterly Journal of Inebriety*: "Probably a direct toxic action is exercised by alcohol on the reproductive elements."

Describing what he called "hereditary alcoholics," Dr Robinovitch said "the most common mental characteristics of such children are feeble memory, inability to learn, and a certain want of perception of the ordinary duties of life." He also cited signs such as microcephalus (small head) and tremors; and various nervous and physical problems, including childhood symptoms of digestive, respiratory, or nervous disorders.

In 1910, a Finnish doctor told the International Congress of Alcoholism in London that drinking during pregnancy affects babies' weights. Reporting on more than 2,000 infants born to his patients in the early 1900s, Taav Laitenen said that those of abstainers averaged the highest birthweight; those of moderate drinkers ("one glass of beer daily") came next; newborns of "drinkers" were the smallest. These weight differences were still evident at "eight months after birth, for the children of the abstainers develop fastest, those of moderates next, while the drinkers' children develop the most slowly."

Research continued, including animal studies which clearly indicated that alcohol itself was dangerous to unborn babies. As early as 1923, A. L. McIlroy observed in a British scientific journal that alcohol goes through the placenta. "Alcohol is a poison," he wrote, "and the fetus of a chronic alcoholic mother is itself a chronic alcoholic, absorbing alcohol from the mother's blood and subsequently from her milk."

Finally, fiction also offers clues to knowledge about the dangers of drinking during pregnancy. For example, in *Pickwick Papers* (1836), Charles Dickens' character Betsy Martin allegedly had only one eye because her mother drank bottled stout. Nearly 100 years later, in 1932, Aldous Huxley created a science fiction community in *Brave New World* where unborn babies lived and developed in scientifically controlled, bottled solutions instead of in their mother's wombs. Character Fanny said with scorn of Bernard: "He's so *small*! They say somebody made a mistake when he was still in the bottle — put alcohol in his blood-surrogate. That's why he's so stunted."

Illustration from The Pennsylvania-New Jersey Almanac, *1835, reprinted in* The Alcoholic Republic *by W. J. Rorabaugh.*

**By Lucy Barry Robe* [2], excerpt from Just So It's Healthy, revised edition, Compcare Publications.

INTERNATIONAL

Heroin concern draws foreign aid

Bonn woos poppy farmers

By Thomas Land

VIENNA — West Germany has committed $3.4 million to an international crop substitution project intended to eliminate opiun-poppy cultivation in the Northwest Frontier Province of Pakistan — the source of 80% of the heroin seized by Britain's law enforcement authorities during 1981.

The province is one of the most productive regions of the Golden Crescent of the Middle East — comprising Pakistan, Afghanistan, and Iran — which supplies nearly half of North America's annual heroin consumption. Its illicit exports also account for a drastic current increase of heroin addiction in Western Europe, which is blamed by the United Nations' International Narcotics Control Board (INCB) here in Vienna for a corresponding rise of drug-related violent crime.

Bonn's financial initiative is part of a national program which includes legislation, passed last year and in force since Jan 1, extending domestic drug control provisions. Similar legislative proposals are under consideration in several West European countries.

Weather conditions and political upheavals shaking the Middle East have turned the Golden Crescent into the global heroin syndicates' richest source of supply. Hence the new agreement, just signed in Vienna and Islamabad by West Germany, Pakistan, and the UN Fund for Drug Abuse Control (UNFDAC). Overall responsibility for the project has been assigned to the UN Development Program.

The program in the Northwest Province will run until 1984. It includes the irrigation of 3,400 acres of land to facilitate the cultivation of a wide range of crops new to the region. An expanded credit program will be introduced to help local farmers with the purchase of fertilizers, improved seeds, and pesticides.

"To help farmers transport their new crops to market, 51 miles of road will be improved," explains a specialist spokesman for the UN fund. "The provision of clean water and the elimination of sources of water contamination are important parts of the plan."

NZ nabbing drugs in letters to Antarctica

AUCKLAND, NZ — Hashish, cannabis, and "magic mushrooms" are being found by New Zealand customs officers in letters and parcels addressed to Americans serving in Antarctica.

The United States state department, defense department, and National Science Foundation, which has overall responsibility for the US Antarctic program, have joined New Zealand authorities in investigating the traffic in illicit drugs to one of the world's most remote outposts.

Already one US serviceman has appeared in New Zealand court in the first of what could be a series of prosecutions. Customs officials say they intend to question about 40 of the 1,000 American men and women stationed in Antarctica as they return from "the ice."

In January a US Navy petty officer was fined $230 for arranging for 10 grams of cannabis leaf to be posted to him for his own use while serving in the Operation Deep Freeze program. The court was told he had asked a friend to send the drug in three letters mailed to the San Francisco post office box for Antarctica servicemen.

Mail for service personnel, scientists, and support workers serving in Antarctica comes to Christchurch, the program's New Zealand operations base, by commercial aircraft. It is transferred to Royal New Zealand Air Force and US Navy Hercules aircraft for the 2,300-mile flight south.

When mail is removed from aircraft on arrival at Christchurch, it has legally been imported into New Zealand and is subject to customs inspection. Customs officers say they have found drugs in more than 50 items, often concealed in foodstuffs to put drug-sniffing dogs off the scent.

Thatcher's shuffle angers UK anti-smoking lobby

'Tobacco barons influenced move'

By Alan Massam

LONDON — The British anti-smoking lobby has developed an uncharacteristic head of steam over the fate of its champion in government, the lofty (6ft 5ins) Sir George Young, who was transferred from the department of health to the department of the environment in Prime Minister Margaret Thatcher's latest ministerial reshuffle.

The move of the dedicated non-smoking Tory undersecretary came as a nasty blow to health educationists, who were banking on his help for their campaign to get much tougher curbs on tobacco promotion supported by legislation this year.

But when *The Observer* newspaper suggested in a front page story that pressure from the tobacco barons had actually provoked the switch, anger spilled over into a bitter protest.

Adam Raphael, political editor of *The Observer*, suggested that the transfer of Patrick Jenkin (former social services secretary) to the department of industry, and Sir George to environment, and the sacking of the Scottish health minister, Russell Fairgrieve, were all seen in Whitehall "as evidence of the success of the tobacco barons' defensive campaign."

Moreover, he noted, when Sir George's successor in the health department, Geoffrey Finsberg, was due to take office, the first thing his officials did was to remove Sir George's anti-smoking posters from the rooms.

Mr Raphael, one of the most respected British political commentators, reported that the tobacco industry had found the former ministerial team at the department of health and social services (Mr Jenkin, Sir George and Gerard Vaughan) "difficult to deal with."

He reported there had been a conversation between the Prime Minister's husband, Denis Thatcher, and Dr Vaughan after which Dr Vaughan returned to his ministerial colleagues and suggested they should take a more relaxed view about the question of sports sponsorship by tobacco companies (the device which the companies are said to have exploited to overcome restrictions on the advertising of cigarettes on TV).

After the surprise removal of Mr Jenkin and Sir George from the department of health, Mr Raphael asked the Prime Minister's political liaison officer, Derek Howe, whether Mr Thatcher had influenced these changes. Mr Howe said it was not his practice to confirm or deny private conversations. He did, however, confirm that Mr Thatcher had had a lifelong interest in the expansion of sports facilities for young people.

The Prime Minister's office was then approached by Mr Raphael and dismissed the allegation of Mr Thatcher's involvement as "scurrilous gossip."

The worst fears of the health educationists were confirmed about two weeks later when the one ministerial survivor, Dr Vaughan, told health correspondents that the government was committed to a *voluntary* approach in seeking curbs on tobacco promotion.

Thus the rather hazy previous hints at possible legislation to restrict tobacco promotion were committed to the ash-can.

The anger of the anti-smoking lobby at this apparent defeat was energetically manifested by the normally quiet-spoken Tom Hurst, chairman of the National Society of Non-Smokers.

Mr Hurst issued a stinging press release in which he expressed "deep concern" about the transfer of one of the society's "great champions," Sir George, from the department of health, and the subsequent announcement by Dr Vaughan that the department's policy of tobacco promotion "was NOT to be achieved by legislation.

"Before the reshuffle, the possibility of legislation to achieve a total ban on cigarette advertising seemed a serious DHSS (department of health and social services) option," Mr Hurst thundered. "It is now widely expected that a new voluntary agreement with the tobacco industry will allow extended sports sponsorship.

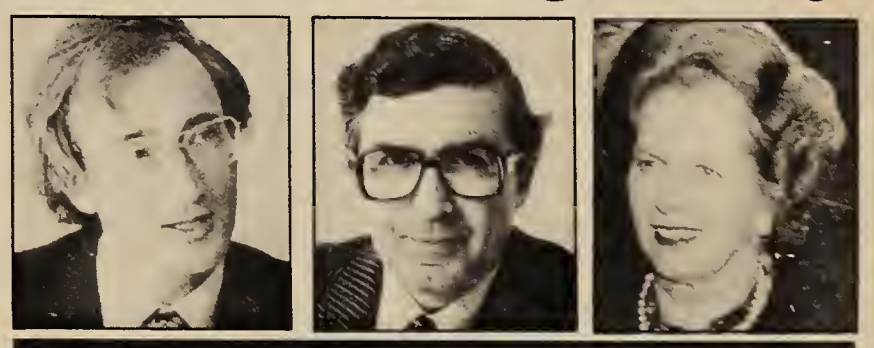
"We feel that the implications of these issues reflect badly on the present government and ask the Prime Minister to refute the allegation (that the reshuffle was the result of the tobacco industry's pressure) immediately.

Later, Mr Hurst told **The Journal** that Mrs Thatcher did answer questions in the House of Commons on the allegation, but not to his satisfaction. She simply denied it and refused to explain Sir George's removal.

What are the political powers of what one might describe as the "anti-health" factions in British society? A former director of the government-sponsored Health Education Council, Alastair Mackie, seemed in little doubt when he addressed the International Conference on Smoking and Youth in Venice in November. Describing the work of health educationists as "the elephant of talk and the mouse of action," he said it was surprising that anything at all had been achieved in the face of the enormous pressures for tobacco consumption. Taken together, these pressures amount to an indoctrination throughout the whole community. The multifarious influences of the tobacco trade include the cooing of the advertisers, the meretricious blandishments of the sponsors, and, above all, the inculcations of the politicians.

Mr Mackie cited examples of politicians using the debating chamber of the British and European parliaments to defend tobacco; to speak disingenuously in favor of advertising when measures to reduce its pernicious effects were discussed; to block the debating of anti-smoking measures by procedural devices; and to deny the medical evidence on the toxicity of cigarettes.

Further, he criticized international bodies like the World Bank for its policy of making no distinction between tobacco and other crops when distributing largesse to farmers. Thus the bank emulates the United States which includes cash to grow tobacco in its "Food for Peace" program.



Hard-line anti-smokers, Sir George Young and Patrick Jenkin, have been removed from the British department of health. Reports associating the Prime Minister's husband with changes were dismissed as 'scurrilous gossip' by Mrs Thatcher's office.

NEWS

Blood flow changes linked to alcohol euphoria

By Barbara Baker

DALLAS — Small amounts of alcohol have been shown to constrict cerebral blood vessels, a finding that may explain the mechanism behind alcohol-induced euphoria.

Previously, the precise effects of ethyl alcohol on the cerebral vasculature were unknown, says Burton Altura (PhD), professor of physiology at the State University of New York Downstate Medical Center in Brooklyn.

Recent animal experiments by Dr Altura and his wife, Dr Bella Altura (PhD), an associate professor of physiology, lead the couple to believe "alcohol makes us euphoric and lightheaded because it constricts blood vessels in the brain, thus reducing blood flow to the point that some neurons are starving for oxygen," he says. (A similar phenomenon was experienced by many pilots in the early part of World War II, whose planes did not have pressurized cabins.)

Using a high-resolution television microscope, the physiologists examined the reaction of cerebral capillaries in rats to various concentrations of ethanol.

The *in-vivo* studies found administration of alcohol, ranging from 0.01% to 10% concentration, when given topically, through the carotid arteries, or intravenously, "markedly curtailed" capillary blood flow, Dr Altura says.

"Reductions in the lumens (interior channels) of the blood vessels ranged from 8% to 65%, depending upon the alcohol concentration," he reported to the annual meeting of the American Heart Association here.

The amount of alcohol in two cocktail drinks may be enough to curtail blood flow in the brain to the point that some neurons do not get enough oxygen to function properly, he says.

The researchers also performed *in-vivo* experiments using the two major arteries that supply blood to the brain (the middle cerebral and basilar arteries) in dogs. The arteries were put into a salt solution similar in composition to blood and then subjected to various concentrations of alcohol. This produced dose-dependent increases in vasoconstriction, similar to those witnessed in the rats.

That the degree of arterial constriction is dependent on the concentration of alcohol in the blood stream can explain the various stages of alcohol intoxication, he says. As the amount of alcohol consumed increases, the increasing curtailment of blood flow affects more areas of the brain.

This explains why the euphoric stage is followed by partial loss of certain abilities (such as the ability to walk straight), unconsciousness, and coma.

He says that in rare cases if the blood supply to the neurons that regulate breathing is cut off, intoxication can result in death.

After studying blood vessels from other parts of the rat's body, Dr Altura has found "the vessels of the brain appear to be unique in their high degree of sensitivity to alcohol." The two researchers found only high concentrations of alcohol produce constriction in the non-cerebral vessels.

They also demonstrated that rats addicted to alcohol gradually develop a tolerance to it in non-cerebral cells — ie higher and higher concentrations of alcohol are required to induce vasoconstriction — when exposed to it for extended periods. They hope to determine whether cerebral blood vessels can develop a tolerance as well.

Previously, the researchers have shown that when cerebral arteries excised from dogs are exposed to LSD, mescaline, or phencyclidine (PCP), they constrict as well. They reported in *Science* (May 29, 1981) that the concentrations of PCP producing near-maximum constriction of cerebral arteries were similar to the concentrations in the blood and brains of humans who had died from PCP overdoses.

DAWN data reliable, system 'most valuable'

UNIVERSITY PARK, PA — Data gathered by the Drug Abuse Warning Network (DAWN) are both reliable and valid, suggests a study at Pennsylvania State University.

The major problem with the DAWN material is that it may underestimate the extent of problems in the United States, say John Swisher, program director of the Center for Research on Human Resources, and Teh-Wei Hu, professor of economics at the university.

The authors reviewed a number of past studies of the network by the Drug Enforcement Administration and National Institute on Drug Abuse, results of which have appeared in several publications, including **The Journal**.

They found that "in spite of expected limitations typical of similar data systems, the DAWN system is by far the most valuable source of information on the status of drug abuse among large segments of urban populations.

"It provides very accurate information on the relative frequency (ranking) of drug abuse in the targeted standard metropolitan statistical areas."

The report notes that while DAWN data are useful for federal agencies, they have also been used effectively by state and municipal authorities to assess and monitor substance abuse patterns in specific areas. As an example, the authors note the success in using DAWN data to reduce the supply of methaqualone in the Miami area.

The researchers say no system is without error, and errors in the DAWN system can be attributed to respondents, instrument design, records, and data processors. As a result of earlier reviews, the system was changed extensively four years ago.

"A much broader usage of the data system could efficiently be achieved by the drug enforcement, prevention, and academic research communities, especially since the DAWN system now provides a high-quality national reporting network of hospitals from which extensive new health data could be retrieved at minimat cost," Drs Swisher and Hu added.

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Susan Reid, the coordinator of the group, at (416) 595-6150.

Cope: Drugs Part 1

Number: 487.
Subject Heading: Drugs and youth.
Details: 29 mins; ¾ inch or ½ inch video-cassette; color.
Synopsis: This tape, concerned with why young people use drugs, combines interviews with teenagers and experts in the field of drug addiction and treatment. Dr Kevin Kehr, Addiction Research Foundation (ARF), discusses PCP, solvents, LSD, and marijuana, Garth Martin, ARF, suggests that people use a drug because "they like it and get some pay off from using it", and Gordon Wolfe, Director of Huntley Youth Services, describes the telephone youth counselling program which they operate. Young people indicate that glue sniffing is not prevalent among them and they talk about drugs in relation to school, drug education, their parents and younger children.
General Evaluation: Poor (1.9). The Group judged this tape to be boring, unrealistic, and lacking emotional impact. The message was unclear due to contradictions between the opinions expressed by the teenagers and the experts; there were, in addition, visual and audio contradictions (eg "glue sniffing is not prevalent" was combined with a shot of young people sniffing glue). The tape was rated as an ineffective teaching aid despite its contemporary nature and appropriate length.
Recommended Use: The tape appears to be intended for adolescents (age 12-18 years) but was judged to be neither harmful nor beneficial to this group. If used, a resource person should be present. It is not recommended for any audience under the age of 12.

Best Friends

Number: 483.
Subject heading: Smoking.
Details: 6 min; 16mm/video-cassette; color.
Synopsis: This animated film traces the developmental stages and concurrent needs of a cartoon character, Lamont. When he was very young the fulfilment of his needs came quite naturally (eg when his stomach growled, he ate). He was quite content to satisfy basic desires. One day Lamont discovered that he was "unique" and began looking beyond his immediate self-fulfilment to other desires and friends. It seemed now that eating, sleeping, and even playing had pitfalls and he discovered cigarettes were useful in coping with the resulting stress. A voice (his conscience) speaks to Lamont suggesting that he is "abusing his friends, the heart and lungs," by smoking cigarettes. The voice questions Lamont as to whether or not he would want his friends "choking in fumes, slugging in nicotine, and drowning in tar?" Lamont realizes that he is not treating his friends, his heart and lungs, very well, he quits smoking, and becomes a hero.
General evaluation: Good (4.1). This film was judged to be a good teaching aid which may produce attitudes against smoking and help in decision-making regarding smoking. Its length is appropriate for most educational settings and the Group felt this still contemporary film should be broadcast.
Recommended use: Likely to benefit children up to 12 years, and was judged to be neither harmful nor beneficial for all other audiences.

Hot Wheels

Number: 481.
Subject Heading: Youth and alcohol; impaired driving; attitudes and values.
Details: 26 min; 16mm; color.
Synopsis: This drama focuses on some of the decisions faced by adolescents such as: drinking and driving, peer-group influence, dating, self-identity, and criminal behavior. The story centres around a group of teenagers who are involved in a number of activities (roller skating, disco). The fun ends in tragedy when one youth "borrows a car" for a few hours to cruise around town.
General Evaluation: Very good (5.3). This contemporary, interesting, and well-produced film was judged to be a good teaching aid which could help young people in decision-making about alcohol and other subjects. The Group liked how the film dealt with these issues and felt it had powerful visual and emotional impact.
Recommended Use: Highly beneficial for its intended audience of adolescents (age 12-18 years.)

RC Method of Smoking Control

Number: 486.
Subject Heading: Smoking; treatment.
Details: 20 min; video-tape; color.
Synopsis: The Relaxation and Concentration (RC) method of smoking control is a psychological technique which utilizes deep relaxation on the part of the participant so that he can concentrate on becoming a non-smoker. Through a series of progressive relaxation exercises and suggestions, such as repeating the phrase "I am a non-smoker", this method attempts to teach a person how to remove the "urge, craving, desire and impulse" to smoke.
General Evaluation: Fair (2.8). This video-tape was judged to be boring, unrealistic, lacking emotional impact, and poorly produced. It was suggested that the choice of medium was inappropriate and the message could have been equally or more effectively presented by means of an audio-tape.
Recommended Use: The tape was judged to be neither harmful nor beneficial to audiences.

DEPARTMENT

New Books

by RON HALL

Addictive Behavior and its Treatment

. . . by Jesse B. Milby

This book is intended for those who wish to learn about drug dependence and behavior patterns associated with it. It is largely a response to the problem of helping colleagues and new staff acquire knowledge of drug dependence so they can help the clients in their charge. It is based on the author's reprint file, organized for inservice training sessions into meaningful units. Topics covered include: understanding addiction; psychological factors; epidemiology of drug dependence; pathology and morbidity; classification of drug dependence; theories of addiction; and treatment issues. The initial chapter dealing with understanding addiction presents basic concepts and definitions, discusses the development of drug dependence and the drug dependent state, and outlines characteristics associated with physical dependence.

(Springer Publishing Company, 200 Park Avenue South, New York. NY 10003, 1981. J.B. Lippincott of Canada, 75 Horner Avenue, Toronto, Ontario M8Z 4X7. 272p. $21.95 ISBN 0-8261-2750-9)

Tobacco: What It Is, What It Does

. . . by Judith S. Seixas

Following the previous volumes *Alcohol: What It Is, What It Does* and *Pot: What It Is, What It Does*, this books presents a simple introduction to facts about smoking, including how smoking started, the effects of smoking on health, and why people smoke. The book is intended for a juvenile audience and is fully illustrated. The introductory chapter presents warning signs, advertising, and statistical information. Adverse effects are presented and explained in a later chapter, and the book concludes with the advice "be smart, don't start."

(Greenwillow Books, available from Gage Publishing, 164 Commander Blvd., Agincourt, Ontario M1S 3C7, 1981. 55p. ISBN 0-688-00769-4)

Drinking and Crime: Perspectives on the Relationships Between Alcohol Consumption and Criminal Behavior

. . . edited by James J. Collins, Jr

This volume examines a number of aspects of the relationship between alcohol consumption and criminal behavior. The guiding theme is that these complex social behaviors cannot be adequately understood within a framework that assumes alcohol directly "causes" criminal activity. The more plausible hypothesis is that drinking has a variable effect on behavior. For example, while certain perceptual and motor skills are directly influenced by alcohol's pharmacological impact, aggressive, violent, and ultimately criminal activities are mediated by cognitive expectations and sociocultural belief systems that interact with the effects of alcohol. Beginning with a review of the theoretical literature, the book explores methodological problems encountered in researching such interrelated complexities. Subsequent chapters examine the roles of environmental variables, family violence, cultural norms, age and life cycle variations, race, and other key factors.

(Guilford Publications, Inc, 200 Park Avenue South, New York, NY 10003, 1981. 384p. $22.50 ISBN 0-89862-163-1)

Alcohol Problems and Alcoholism: A Comprehensive Survey

. . . by James E. Royce

This book gives perspective on the claims and approaches regarding the causes, nature, and treatment of alcoholism and it examines the problems that result from excessive drinking. The first part examines the nature of alcohol problems, looking at alcohol as a drug and the distinction between the problem drinker and the alcoholic. Chapters discuss the scope of problems, the costs related to alcoholism, socio-cultural attitudes toward drinking, and prohibition. Alcohol's effects on the body are explored, along with fetal alcohol syndrome and alcohol's effects on behavior. The second part discusses the symptoms, types, and progression of alcoholism; denial; the impact of alcohol on women, adolescents, minorities, the elderly; its effects on the family; and the disease concept. The third part deals with prevention and intervention, while the concluding part presents information on treatment and rehabilitation. The bibliography includes more than 750 entries.

(The Free Press, 866 Third Avenue, New York, NY 10022, 1981. 383 p, $16.95, ISBN: 0-02-927540-7)

Other Books

The Narcs' Game: Organizational and Informational Limits on Drug Law Enforcement — Manning, P. K., MIT Press, Cambridge, Mass, 1980. A sociologist draws on extensive field experience in two Southeastern drug enforcement units to explore the police role in drug control in the United States. Index. 316p.

The Alcoholism Services Delivery System — Paredes, Alfonso (ed), Jossey-Bass, San Francisco, 1981. Mission and structure; social matrix and sources of management information; resource use and community impact; physician in the treatment centre; Indian programs; therapeutic outcome; cost outcome methodology in assessment. Index. 98p.

Clinical Implications of Drug Use. Volume I — Basu, Tapan Kuman (ed), CRC Press, Boca Raton, 1980. Principles of drug metabolism,; drug dosage and pharmacological consequences; pharmacogenetics. References, index. 145p.

Opioid Dependence: Mechanisms and Treatment — Wikler, Abraham, Plenum Press, New York, 1980. Problems of opioid and other drug dependencies; etiology; analgesics and antagonists; receptors and endogenous opioid peptides; theories of tolerance to and physical dependence on opioids; conditioning processes; diagnosis and treatment. References, index. 255p. $27.50.

Drugs in Perspective — Plant, Martin, Hodder and Stoughton, London, 1981. Background; drugs and their effects; why people use drugs; drugs and the law; patterns of drug taking; drug problems. Bibliography, index, appendix. 210p. $11.75

Drugs, Alcohol and Sex — Bush, Patricia J., Richard Marek Publishers, New York, 1980. Overview; aphrodisiacs; prescribed and over-the-counter medications; recreational drugs. References, appendix, index. 287p.

American Association for Automotive Medicine: Proceedings of the Twenty-Fourth Conference — Moffatt, Edward A., American Association for Automotive Medicine, Morton Grove, 1981. Meeting held Oct 7-9, 1980 in Rochester; alcohol and other drugs; driver licensing policy and procedures; cash research theories; occupant restraint; heavy truck safety; injury studies; emergency medical services. 516p.

Proceedings 1870-1875 — American Association for the Cure of Inebriates, Arno Press, New York, 1981. Reprint of the works first published 1871-1875 by various publishers. 424p.

Opium and Narcotic Laws — Walsh, Gerard P., Jr, US Government Printing Office, Washington, 1981. 351p.

Alcohol/Safety Public Information Materials Catalog, Number 5 — Grimm, Anne C. and Huber, Kristina R., Public Information Materials Center, University of Michigan, Ann Arbor, 1981. List of materials for campaigns along with journal articles and reports describing and evaluating such programs. 239p.

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DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Medication Awareness Week — Mar 29-Apr 3, Hamilton, Ontario. Information: Nancy Rocchi, 180 McNab St S, Apt 203, Hamilton, Ont L8P 3C6.

Detox Training Program (Non-Medical) — Apr 19-23, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell Street, Toronto, Ont M5S 2S1.

Cognitive Behavior Therapy — May 14, Toronto, Ontario. Information: E. Essue, Clarke Institute of Psychiatry, 250 College Street, Toronto, Ont M5T 1R8.

Mental Health Information Systems: Problems and Prospects — May 14-15, Toronto, Ontario. Information: Hincks Lectures, Ontario Mental Health Foundation, Suite 1708, 365 Bloor Street E, Toronto, Ont M4W 3L4.

73rd Annual Conference Canadian Public Health Association — June 21-24, Yellowknife, Northwest Territorities. Information: Gerald H. Dafoe, Executive Director, Canadian Public Health Association, 1335 Carling Avenue, Suite 210, Ottawa, Ont K1Z 8N8.

Summer Course in Addictions — July 19-23, Toronto, Ontario. Information: School for Addiction Studies, 8 May Street, Toronto, Ont M4W 2Y1.

Workshop on Evaluation Research in the Addictions Field — Sept 7-9, Regina, Saskatchewan. Information: Brigitte Neumann, Nova Scotia Commission on Drug Dependency, 5668 South Street Halifax, NS B3J 1A6.

United States

Family Program For Professionals — Offered once each month, Center City, Minnesota. Information: Continuing Education Department, Box 1I, Center City, MN 550I2.

Alcohol/Drug Series — Mar 3-5, Apr 28-30, Center City, Minnesota. Information: Continuing Education Department, Box 1I, Center City, MN 55012.

Issues of Sexuality in Alcoholism/Drug Abuse Counselling — Mar 11-13, June 3-4, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 550I2.

Alcohol/Drug Dependency and Mental Illness — Mar 15-16, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Pharmacology for the Alcohol/Drug Counsellor — Mar 22-23, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 550I2.

Group Skills — Mar 24-26, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

American Orthopsychiatric Association 59th Annual Meeting — Mar 29-Apr 2, San Francisco, California. Information: The American Orthopsychiatric Association, Inc, 1775 Broadway, New York, NY 10019.

Third Regional Conference on Substance Abuse — Mar 31-Apr 1, Cincinatti, Ohio. Information: Ann Blankenhorn, Central Community Health Board, 532 Maxwell Avenue, Cincinnati, OH 45219.

National Alcoholism Forum of the National Council on Alcoholism — Apr 2-5. Washington, DC. Information: Forum Coordinator, National Council on Alcoholism, Inc, 733 Third Avenue, New York, NY 10017.

Course for Physicians: Medical Aspects of Alcoholism — Apr 2, Washington, DC. Information: Claire Osman, American Medical Society on Alcoholism, 733 Third Ave, New York, NY 10017.

Principles of Comparative Pathology — Apr 14-16, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Assessment and Diagnosis For Chemical Dependency — Apr 16, June 8, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

First National Symposium on Psychoimmunology — The Impact of Brain, Behavior and Emotion on Immunity to Disease — Apr 24-25, New York, NY. Information: Institute for Psychosocial Study, 221 E 50 Street, NY 10022.

Midwest Conference on Alcohol and Drug Abuse — Apr 25-29, Midland, Michigan. Information: James R. Tarrant, Director of Medical Education, 615 Ninth Street, Bay City, MI 48706.

Two Rival Psychotherapies Move Toward Convergence — May 1, New York, New York. Information: Institute for Psychosocial Study, 221 E 50 Street, New York, NY 10022.

8th Annual School on Addictions Studies — May 3-6, Anchorage, Alaska. Information: Janice Oglietti, Coordinator, Center for Alcohol and Addiction Studies, University of Alaska, Anchorage.

Outcome Evaluation for Alcohol and/or Drug Treatment Programs — May 6-7, Center City, Minnesota. Information: Continuing Education Department, Box 1I, Center City, MN 55012.

7th World Conference of Therapeutic Communities — May 8-13, Chicago, Illinois. Information: Donna Gleixner, Gateway Houses Foundation, Inc, 624 S Michigan Avenue, Chicago, IL 60605.

Pastoral Training for Chaplains in Rehabilitation Settings — May 10-12, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Nursing Series — Pharmacology, Detoxification and Withdrawal: Basic Skills, Counselling Skills for the Nurse — May 17-21, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Toxicology of the Immune System — May 20-21, East Brunswick, New Jersey. Information: PO Box H, East Brunswick, NJ 08816-0257.

Alcohol/Drug Counselling Skills II — May 24-28, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Fundamentals of Biochemistry and Genetic Engineering — June 2-4, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

The Mid-South Summer School on Alcohol and Drug Problems — Prevention and Treatment — June 20-25, Fayetteville, Arkansas. Information: Gwen Briscoe, GSSW-UALR, Little Rock, AR 72204.

33rd Annual Symposium on Alcoholism — June 21-July 2, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, 12th and E Columbia, Seattle, WA 98122.

Alcohol Studies Program — June 21-Aug 13, Seattle, Washington. Information: Alcohol Studies Program, Seattle University , 12th and E Columbia, Seattle, WA 98122.

Sexuality for Alcoholism Counsellors — June 22-July 3, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, 12th and E Columbia, Seattle, WA 98122.

Alcoholism, Culture and Treatment: Comparative Perspectives from Europe and America — Conference Committee, University of Connecticut Alcohol Research Center, Department of Psychiatry, University of Connecticut Health Center, Farmington, CT 06032.

Scholarly Communication Around The World — The 27th Annual Conference of the Council of Biology Editors, The 3rd International Conference of Scientific Editors and The 5th Annual Meeting of the Society for Scholarly Publishing — May 15-20, 1983, Philadelphia, Pennsylvania. Information: 1983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Service, 2100 Arch Street, Philadelphia, PA 19103.

Abroad

ALC 82, International Conference on Alcoholism — Mar 30-Apr 4, Oxford, England. Information: Dr Philip Golding, Broadway Lodge, Oldmixon Road, Weston-super-Mare, BS24 9NN, Avon, England.

10th International Conference of Social Gerontology — May 26-28, Deauville, France. Information: ICSG, 91, rue Jouffroy, 75017 Paris, France.

First Nordic Congress on Traffic Medicine — June 8-11, Linköping, Sweden. Information: Leif Bohlin, Congress Director, Linköping University, S-581 83 Linköping, Sweden.

13th Collegium Internationale Neuro - Psychopharmacologicum Congress — June 20-25, Jerusalem, Israel. Information: Secretariat, 13th CINP Congress, P0B 29784, Tel Aviv, Israel.

28th International Institute on the Prevention and Treatment of Alcoholism — July 5-9, Munich, Fed Rep of Germany. Information: International Council on Alcohol and Addictions, Case postale 140, 1001, Lausanne, Switzerland.

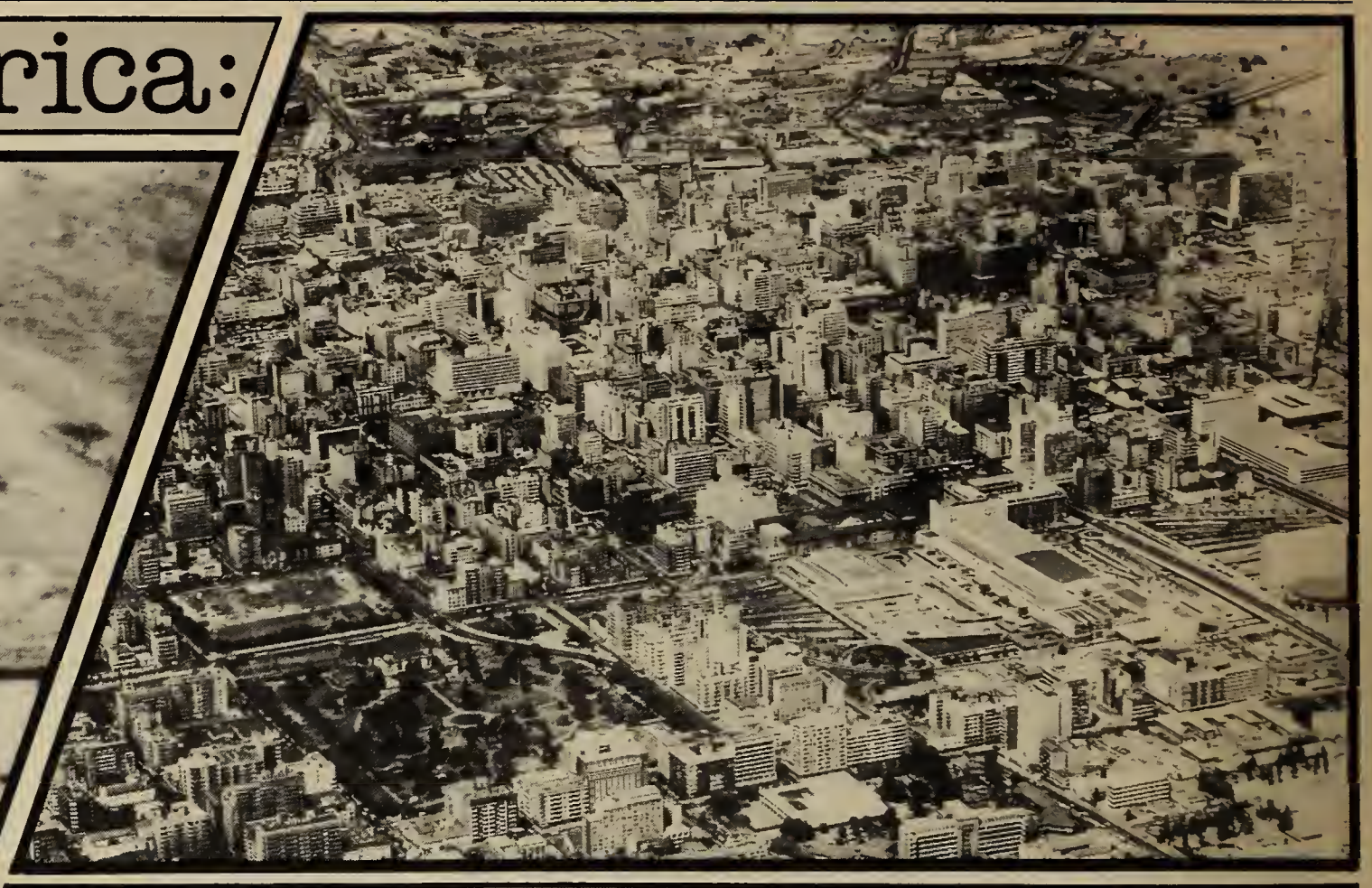
Second Biennial au School of Justice Institute on Juvenile Justice — July 11-30, London, England. Information: Dean Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

11th International Conference on Health Education — Aug 15-20, Hobart, Tasmania, Australia. Information: Joy Faldt, Australian Society of Health Educators, PO Box 818, Fortitude Valley, Queensland, Australia 4006.

Fourth World Congress for the Prevention of Alcohol Problems, Alcoholism and Drug Dependency — Aug 29-Sept 2, Nairobi, Kenya. Information: ICPA — International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St NW, Washington, DC 20012.

33rd International Congress on Alcoholism and Drug Dependence — Oct 9-15, Tangier, Morocco. Information: Archer Tongue, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

South Africa:



A shifting mosaic

Complex cultural framework confounds consensus on alcohol

By Peter Unwin

In the United States of America this material is filed with the department of justice . . . Such registration does not indicate approval of this material by the United States government."

That disclaimer appears on a catalogue of South African health and hospital services. It reflects the uneasiness of dealing with South Africa on any level.

The uneasiness concerns the legal separation of cultures in South Africa: of whites, of blacks, of coloreds, and Indians.

Uneasy or not, professionals in aspects of the alcohol field attended a conference in Johannesburg late in 1981, to exchange current and not-so-current information.

Much of it had been heard before at similar conferences around the world; the powerful South African Breweries (SAB) delivered a well-prepared text, as other breweries do, dismissing control measures: ("We warn against the slavish extrapolation of per-capita figures") and suggesting the fewer the restrictions, the fewer the abuses.

SAB also advertise heavily in South Africa, where television lifestyle ads are drawing criticism. Though speeches warned of a lack of information on the effects of advertising, SAB's stand was clearly stated: "Advertising . . . cannot cause movement in overall consumption."

The SAB is a strong, lucrative industry, comfortable in the status quo. In 1980 it recorded a 34% increase in profits. Those profits seem secure. As the SAB is quick to point out, "to tax beer even further when it is so much a part of the social fabric of the black people may be running the risk of inviting serious reaction from them some time in the future."

The SAB position is supported by SANCA (the South African National Council on Alcoholism and Drug Dependence). In a speech presented by Chief Director Colin Wenman, care was taken not to offend the alcoholic beverage industry: "As a legitimate industry, operating within a free-enterprise economy, it cannot be expected to take kindly to any attempt to subject it to restrictions . . ."

Controls in South Africa are confounded by the number of ethnic groups. Who are the controls for? Blacks, coloreds, Indians, or everyone? That multiplicity involves itself in every aspect of information gathering in South Africa.

In rejecting control measures the SANCA admits its decision is based on limited data; Mr Wenman concluded by recommending that "research facilities capable . . . of monitoring consumption trends in South Africa be created as soon as possible."

Need for information was a constant, underlying theme through the conference. Speeches began with pleas for greater efforts to collect it and assimilate it. Often they ended on the same note.

'. . . Imagine the complexities involved of say, a black, male field-worker gathering information on the drinking habits of Indian women and delivering it to a white research organizer . . .'

In the face of swift relocation and urbanization, there are large knowledge gaps. A research technology capable of assisting in the first heart transplant often comes up empty when it focuses on South Africa now, and what is known about the effects of alcohol on its 25-million inhabitants.

In declaring alcohol abuse a "national problem," the department of health, welfare and pensions, in Pretoria, sets down a number of aims. The first is to conduct a study on the per-capita consumption of alcohol in order to determine acceptable norms.

The complexities of conducting and collecting those studies are making themselves felt. South African doctors and researchers stress the need, not only for the information, but also for better systems of storing it and retrieving it. The information needed is myriad and difficult to pinpoint. It can change in a week, as factories close (or open) and the patterns of urban migration shift.

In any country, the possibility of collecting pure, objective data will have its detractors. Quoting Jessor *et al*, Lee Rocha-Silva of the South African Human Sciences Research Council noted that: ". . . observation can never be achieved in 'raw' form — no facts exist independently of the observer's interpretive apparatus."

In South Africa this basic problem is multiplied. Imagine the complexities involved of say, a black, male field-worker, gathering information on the drinking habits of Indian women, and delivering it to a white research organizer.

There is also the problem of dealing with new information and the shifting of social attentions to areas never before researched. An example was given in a paper on women and alcohol prepared by a Johannesburg professor:

"Since only during this last decade has women and alcohol come to be a topic in its own right, there is yet very little to report."

In the speech were listed five texts of "major importance," cataloging what is known about women and drinking. All of them are published abroad. The speaker concluded by recommending key data be stored in a central computerized system.

The theme was reiterated by Dr S. de Miranda, director of clinical services, SANCA, Johannesburg, in a paper on youth and alcohol: "To put youth and alcohol abuse in perspective as it relates to South Africa . . . the author has looked at some available data (and lack of data) . . . and has conducted a number of surveys . . . to determine any discernible trends.

"The lack of a meaningful national survey on the extent of substance abuse (including alcohol) in our school-going population (of all races) is deplorable . . . Such surveys are needed as a matter of urgency . . ."

Developments in the wider field of understanding can also often leave individual countries with no research base. Fetal alcohol syndrome (FAS) is an example of an issue that surfaced quickly, and is now being heavily researched. How applicable is foreign data to the complicated inter-ethnic organization of South Africa? How does it bear on the Indian woman whose societal role frowns on her use of alcohol, or the white woman, who is encouraged?

A paper on this subject was presented by Genetic Services, department of health, welfare, and pensions. The facts on FAS were dutifully laid down. All the information was culled from foreign texts, all 46 studies listed in a bibliography were from outside of South Africa.

The report concludes, limply: "Perhaps a task force on alcohol-related disabilities will be established in the Republic of South Africa as a result of this conference. If so, the Genetic Services would be glad to make a contribution in the endeavor to prevent fetal alcohol syndrome."

The problem of deciding when a country has passed the "threshold" of an alcohol problem is a sticky one, with lots of room for equivocation. Before direct policy can be implemented, the information must be assembled, a consensus must be reached as to its meaning.

In South Africa, that consensus is not to be found.

Within the conference, however, there was some agreement. Representatives of the church felt there was enough information to label alcoholism "the main addiction problem in South Africa."

Perhaps the strongest, and in some ways the most political stand at the conference, was taken by the South African clergy. Said Min R. Storey, Central Methodist Church, Johannesburg: "The poor (and therefore black) constituency in our society ought to be made fully aware that liquor is an instrument of oppression, contributing to their imprisonment in deprivation."

Regardless of their willingness or unwillingness to act on the limited data, South African speakers themselves were almost unanimous in their demand for more of it.

Often, at any conference, even one concerned with a lack of information, there is a surplus of facts — data collected for their own sake, to fill a paper. There is a German word for it; it means the science of knowing what is not worth knowing.

An example at the South African conference was this, from a factory medical officer: "A typist, after four units of alcohol (two beers) . . . has a 72% increase in her typing errors."

The study had not been conducted in South Africa.

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It's back to basics for drug policy planning at the White House, says Carlton Turner ... p9

Vol. 11 No. 4 TORONTO April 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Medical risks a matter of debate

US approves paraquat at home, abroad

By Harvey McConnell

WASHINGTON — Approval has been given for the use of the herbicide paraquat on marijuana grown in the United States and for foreign governments to use US aid money for such projects.

Congress, in the latest Foreign Assistance Act, has removed a clause which for several years had prohibited American aid money from being used by other governments for spraying of marijuana crops.

On the domestic front, the Drug Enforcement Administration (DEA), acting on advice from the Environmental Protection Agency, (EPA) has approved the use in the US of both paraquat and another herbicide, 2-4-D, on marijuana crops.

In 1978, the department of health and human services, then under Joseph Califano, said marijuana tainted with paraquat could lead to lung damage for regular and heavy users of the drug.

The latest marijuana and health report, issued by the Institute of Medicine, National Academy of Sciences, said to date, evidence concerning the injurious effect of paraquat inhaled after either spraying or smoking "is too meagre for conclusions. The observations available since 1975 have not proved that paraquat, per se, is harmful to the lungs."

On the other hand, the report continues, clinical evidence to date, coupled with the increasing understanding of the biochemical basis for paraquat toxicity, "raises the serious possibility that continued exposure to inhaled paraquat is likely to be harmful to the lungs, that the predominant effect will be diffuse interstitial fibrosis, and that if exposure is sufficiently intense over years, respiratory insufficiency, difficulty, and death may reasonably be expected to ensue."

Commenting on the decisions, Carlton Turner, White House senior advisor for drug policy, told **The Journal**: "Paraquat is the most commonly-used herbicide in the world and people forget that. They forget that it is photodegradable and biodegradable.

"They forget there has never been a single case of lung problem that could be attributed to marijuana contaminated with paraquat that could not be attributed to marijuana."

Dr Turner noted that paraquat is a legal commodity in the US, "and can be sprayed in any state in the United States for weed control, and marijuana is a weed. If any state wants to eradicate cannabis they are perfectly within their rights to eradicate it."

He pointed out that the United Nations decided in 1979 that the most effective way to control illegal drugs is eradication of plants at the source. Evaluation of the different methods to do so concluded the use of herbicides was the most palatable for the environment, as well as being the least expensive and the most efficient.

Dr Turner added: "I think we have a tendency to knee jerk and think of DDT and the worst possible case when you mention herbicides. We forget the problems narcotic plants are causing to our society."

Dr Turner hit out at critics who have argued that the US should not expect other countries to spray paraquat when the US is not using herbicides, or to use it in aerial spraying.

Dr Turner: "We were using 2-4-D in Kansas years ago on cannabis. When you look at cannabis being cultivated in this country you don't have big fields which justify planes going over and spraying.

"As for paraquat being used domestically: most Americans don't know, for example, 60,000 pounds of paraquat is used in the state of Florida each year in agriculture."

Dr Turner said that while paraquat is effective against marijuana, it would be less so against the coca plant, the source of cocaine. The coca bush is a woody type of plant which would call for a different type of herbicide.

Reagan sends in troops to fight drug lawlessness

MIAMI — A drive has been launched by the United States government to crush the lawlessness in south Florida caused by drug trafficking.

US Vice-President George Bush is coordinating actions through a special presidential task force which involves a number of federal bodies, including the Coast Guard and Internal Revenue Service (IRS).

President Reagan appointed the task force to find ways to handle "rampant crime and epidemic drug smuggling" in south Florida. Task force members include the secretaries of state, defense, transportation, treasury, and health, and the attorney general.

Vice-President Bush spelled out some of the actions in a speech here, and made it clear the drive against drug trafficking will be relentless.

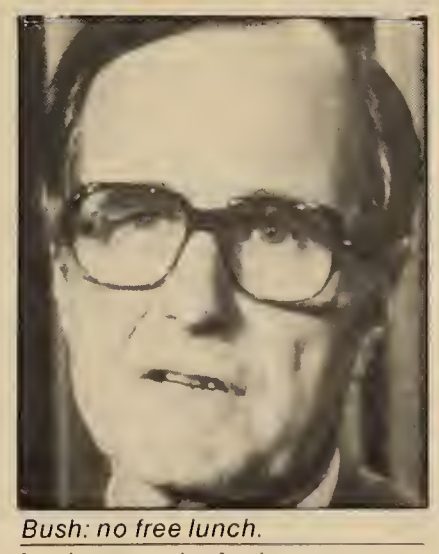
"I want to make this point as strongly as I can: our investigative efforts will be as stringent on bankers and businessman who profit from crime, as on drug traffickers, the drug pushers, the hired assassins, and others.

"There will be no free lunch for the white-collar criminal."

Actions will go beyond the Florida area. Secretary of State Alexander Haig will work directly with the governments of Peru, Bolivia, Colombia, and Jamaica to cut the flow of illegal drugs into the US.

(One early success reported by Mr Bush's office was the seizure by the Coast Guard of a Colombian ship, loaded with 20 tons of marijuana, 260 miles off the Colombian coast. The Coast Guard was able to take such action on the high seas because the US state department received permission from the Colombian government to board and seize contraband on the Colombian ship.)

Mr Bush said Mr Reagan will appoint a new US attorney for the Miami area, who will be given a staff of assistants versed in combatting organized crime.



Bush: no free lunch.

An administrative agreement has been worked out between the justice and treasury departments to set up a joint force consisting of the Drug Enforcement Administration (DEA), the Federal Bureau of Investigation (FBI), and the Customs Service which

(See — Task — page 2)

World drug traffic unrelenting: UN

International terrorism link feared

By Anne MacLennan

VIENNA — Drug abuse and trafficking worldwide have reached staggering dimensions and grow worse annually. And there are now fears international terrorist groups may be involved.

This was the picture painted at the meeting here of the 30-member United Nations Commission on Narcotic Drugs, the main policy-making body for UN drug control.

The picture includes rising addiction, spreading drug abuse, increasing numbers of substances used, and booming illegal narcotic sales.

Reviews of world trends pointed out:

- Cocaine traffic is continuing its "inexorable expansion." The amount seized more than doubled between 1978 and 1980 reaching almost 12 tons in 1980, nearly five times more than the total weight of heroin seized.
- About 6,000 tons of cannabis, more than 1,050 tons of cannabis resin, and more than one ton of liquid cannabis are seized annually. "It is doubtful, however, that total seizures are an accurate indication of the widespread availability of this drug," said a report prepared by the Division of Narcotic Drugs (DND).
- More than 2.5 tons and more than 25 million dosage units of depressant drugs were seized in 1980, largely diverted from licit sources.
- As much as 600 tons of opium from a bumper poppy crop in Southeast Asia is en route to the world blackmarket. This is a three-fold increase over 1980 and will augment enormous quantities of opium already flowing from the Middle East.
- Traffickers in both regions (Southeast Asia and the Middle East) are seeking new outlets, and a number of countries previously untouched by illicit traffic in opiates are now being affected.
- Clandestine heroin manufacture is no longer attempted primarily in areas close to opium production, but is being diversified; opium, morphine, and heroin base are being moved for final preparation closer to intended markets.
- Attempts to smuggle drugs through the post office mails is increasing, and is a profitable way of

(See — Illicit — page 2)

INSIDE

NEWS

Briefly...

Revenge a threat

MIAMI — Law enforcement officers, prosecutors, and judges here are becoming the targets of drug gangs seeking revenge. Since Eugene Berry, an assistant state attorney, was murdered in January, police have been taking death threats to those capturing, or sentencing drug smugglers, seriously. They have assigned bodyguards to several federal judges and prosecutors. But, says Joseph D'Allesandro, state attorney in the same office as the late Mr Berry: "You can't go through life looking around corners and behind trees. If you let it become an obsession, you can't function." The murder rate in the Miami area is the highest in the United States, largely because of the illicit drug trade, authorities believe.

Pot polls in

OTTAWA — Although hundreds of thousands of adolescents and adults smoke marijuana regularly, many are not fully aware of the legal risks, two recent Gallup polls show. Young users in particular view pot as no great risk to health or driving ahility, and are not well informed about the legal consequences of using or selling it. (Thirty per cent of youths 18 to 19 years, 32% of those 15 to 17, and 19% of those 18 to 29 had used pot at least once during the month preceding the polls.)

Beer begets gasohol

IOWA STATE UNIVERSITY — The cheapest way to make gasohol may be to extract alcohol from heer. Scientists at Iowa State have developed a method of pumping heer through silicon dioxide (found in sand, quartz, and other minerals), which traps huhhles of ethanol for easy extraction. This is cheaper and yields more ethanol than other means of gasohol production. The reseachers received their grant from the department of energy just before President Reagan slashed funds.

Cocktails as therapy

SHAWNEE, KA — To comhat alcohol ahuse, a mental health centre here throws cocktail parties. Since 1979, the Johnson County Mental Health Center has heen teaching people "sensible" drinking and discussing the consequences of abuse through a program of cocktail parties called "A New Taste of Wine." Response from participants has been favorahle, and while director Betty Blackmon admits there are no supporting statistics, she considers the parties useful. "It's hard to measure something not happening to a person," she says. The program is suffering from dwindling funds. Only one cocktail party was held in 1981.

No smoking zone

EMMAUS, PA — Next Jamnary, a puhlishing company here will start to practise what it preaches. The offices of Rodale Press, publisher of *Prevention* and other health magazines, will hecome a no-smoking zone. The new policy, announced to the 800 employees last month, resulted partly from complaiots hy nnn-smoklng workers.

Traffickers are rich, sophisticated

In-transit drugs swamping Caribbean

VIENNA — The flood of illicit traffic across the Caribbean to North America is currently "the single, most-aggravated situation we face," a United States official told the meeting here of the United Nations Commission on Narcotic Drugs.

Gene R. Haislip of the US Drug Enforcement Administration (DEA) said the traffic, with its attendant violence and corruption, threatens to poison "virtually all of the nations of the Caribbean community."

It involves tons of cocaine, methaqualone, and ocean-going vessels laden with cannabis.

"The traffickers have millions of dollars at their disposal and readily purchase aircraft up to the four-engine size, cargo vessels, firearms of all sorts, and the latest in electronic communication and detection gear.

"This gives them the capability to operate in any country bordering the Caribbean, even in remote jungle areas."

Mr Haislip, director, office of compliance and regulatory affairs, said the situation has grown steadily worse and requires massive attack by concerned governments.

"The United States is the first to realize it must also greatly increase its own effort since most of this traffic is in response to the demand within its own borders."

He said new legislation allowing US military units "a more active role" in the Caribbean will result in increased attention by both the navy and air force to drug smugglers operating at sea and in the air.

"Further, it is our intention to assist other concerned Caribbean governments in their efforts to eradicate illicit cannabis cultivation by means of aerial herbicides . . . Heretofore, we have also been handicapped in these efforts because of legal impediments."

A principal drug in the Caribbean traffic is methaqualone, but amphetamines and diazepam are becoming a problem, and diversion of psychotropic drugs in general requires more strenuous international attack, he said.

Although customs services of some nations have learned how to search for, and find heroin and cannabis, they are often not aware of movement of psychotropic drugs themselves, or the chemicals essential for their illicit manufacture.

In addition, he said, legitimate brokers in some major ports have been found to be in collusion with traffickers and help to disguise drug shipments.

'Lookalike' speed clouds statistics on student drug use

WASHINGTON — Use of stimulants among United States high school students appears to be on the increase but researchers are not sure this is an accurate observation.

The issue is clouded by the use of legal, over-the-counter preparations and the sale on the streets of fake ("lookalike") pills which look like amphetamines but contain caffeine.

The apparent increase was reported by Lloyd Johnston, PhD, program director of the Institute for Social Research, University of Michigan, in the latest study by him and his colleagues on drug use among high school seniors for the NIDA (National Institute on Drug Abuse).

The report found that the use of marijuana, PCP, tranquillizers, and nitrite inhalants has continued to drop, cigarette smoking is down, and cocaine use has remained stable. Alcohol use remained constant again, as Dr Johnston earlier predicted (**The Journal**, Feb).

As for the apparent rise in stimulant use, Dr Johnston said: "We are having some difficulty sorting out how much of the rise is due to an increasing use of controlled, prescription-type stimulants versus how much is due to stimulants which are sold over the counter or by mail." These would include diet, stay-awake, and pep pills.

There is also a traffic in lookalike, pseudo-amphetamine drugs, which contain caffeine.

For these reasons, the report says, the reader "is advised to view the recent, amphetamine-use statistics with some caution."

Some 32% of the 1981 high school seniors reported they had tried amphetamines, and 16% said they had used them in the past month.

Dr Johnston and his colleagues note in their report that the two classes of drug use which are not actually amphetamine use, but which may be inadvertently reported as such, reflect two different types of behavior.

Their report says: "Presumably, users of over-the-counter diet and stay-awake pills are using them for functional reasons and not for recreational purposes. On the other hand, it seems likely that most users of the lookalike, pseudo-amphetamines *are* using them for recreational purposes.

"Thus, the inclusion of the lookalikes may introduce a bias in the estimates of true amphetamine use, but not in the estimates of a class of behavior — namely trying to use controlled stimulants for recreational purposes.

"Some would argue that the latter is the more important factor to be monitoring in any case."

Nearly two tons of Colombian cocaine were seized by US Customs officials in Miami last month as part of a massive clamp-down on drug smuggling.

Task force 'with teeth' will converge in Florida to fight drug crime

(from page 1)

will allow Customs to investigate drug-related crime.

"In order to provide this joint task force with teeth, we will put 130 more customs investigators into south Florida immediately," Mr Bush said.

The Miami office of the FBI will acquire an additional 43 agents, and 20 more DEA agents will be sent to the area.

Mr Bush said a financial law enforcement centre is being set up by the treasury department. It will have 18 experts initially and 20 more will be added to work on the "laundering" of money earned from drug smuggling.

Mr Bush said the Bureau of Alcohol, Tobacco and Firearms (BAT) is being dismantled by the administration, and responsibility for firearms will move to the Secret Service.

Mr Bush: "We will be beefing up the Secret Service in order to launch an aggressive program to cut back on the illegal use of firearms."

The vice-president said he will work with Attorney General William French Smith and Supreme Court Chief Justice Warren Burger to see that more judges are appointed in south Florida. More courtrooms are also needed to expedite a backlog of cases.

The Coast Guard "will immediately, and significantly increase its forces and manpower in the south Florida area to help in the coming months with the interdiction of illegal drugs and aliens," Mr Bush continued.

The US Air Force will resume aircraft radar surveillance. Other agencies will coordinate with the air force in this operation.

Mr Bush said a new position has been created in the Internal Revenue Service to be called assistant commissioner for criminal investigations, "and will allow the IRS to conduct a more aggressive approach to the prosecution of tax-related drug crime."

Mr Bush said the efforts in Florida should not be subject to partisan politics. "We do not want politicians tripping all over themselves attempting to take credit for whatever success may be achieved."

Illicit drug money funnelled for firearms

(from page 1)

moving large quantities of drugs in small-scale, high-frequency consignments with reduced risks of detection.

Concerns surrounding involvement of terrorist groups came in a report from a sub-commission on illicit traffic. The report said there are growing indications international criminal organizations are using profits available from large-scale international drug traffic to finance other criminal activity.

"Bearing in mind concern already expressed over links between drug trafficking and other crime, especially illegal traffic in firearms . . . the meeting of the sub-commission urged all concerned to make a particular effort to determine the precise links between drug trafficking, the illegal movement of firearms, and other serions crimes so that an accurate picture could be developed as a basis for possible countermeasures."

Another report noted that "heavy involvement" of organized criminal groups not only in drug traffic but "probably terrorism" have lead to "improved and highly sophisticated methods of concealment, particularly in commercial goods, and a new trend to exchange drugs between trafficking groups."

Officials of the UN division, and delegates to the commission, repeatedly noted that while larger drug seizures reflect increased international cooperation and coordination, they also reflect increasing demand for drugs worldwide.

"The plague of drug abuse continues," C. E. Bourgonniere, director of the UN office in Vienna, speaking on behalf of the UN secretary-general, told the commission.

"Availability and trafficking . . . are on the increase, with their hazardous effects on public health and socio-economic stability.

"Drug-related deaths have continued to increase in some countries. In others," he said, "links between drug trafficking and other crimes are becoming more firmly established and there is concern that the enormous profits to be made from illicit drug traffic can lead to other forms of anti-social activities."

NEWS

Licorice may be 'semi-addictive': NZ study

AUCKLAND, NZ — Licorice, an age-old staple of confectionery that also masks unpleasant tastes in cough lozenges and medicines, has "semi-addictive" qualities for some people, says a study here.

After citing case histories implicating licorice as the cause of fluid retention, hypertension, and hypokalemia (abnormally low blood potassium), two researchers at the Otago Medical School conclude packets should carry a warning that excess use of licorice can be dangerous.

In particular, they say, people who have cardiac disease, or a personal or family history of high blood pressure, who eat a lot of salt, or who are taking thiazide-type, diuretic drugs should be particularly sparing in its use.

"Finally," they report in the *New Zealand Medical Journal* (Jan 27) "the medical profession should bear in mind that licorice usage is widespread and should ask all their cardiac, hypertensive, and edematous (fluid retention) patients whether they eat licorice in any considerable quantities."

To gauge the addictive qualities of licorice — also spelt liquorice — Dr F.O. Simpson, a professor of medicine, and I.J. Currie, a medical student, surveyed the intake of 603 high school pupils.

They found black licorice straps, twists, laces, etc, were eaten every week by 29% of the girls and 17% of the boys (licorice was available at the girls' school canteen, but not at the boys').

No less than 21% of the pupils admitted to having a craving for licorice, and 15% had heard it was "good for you."

"It is also of interest that 6% of users said it 'made them feel good;' conceivably it can give a feeling of well-being. There does, in fact, seem to be an element of addiction in the way that some people use licorice," the researchers report.

At least 200 grams were eaten weekly by 5.9% of the girls and 4.9% of the boys, and at least 500g by 1.8% of the girls and 1% of the boys. Two pupils reported intakes exceeding 1,000g a week.

The significance of these figures, the researchers say, lies in the fact that the harmful effects of licorice have been reported from quantities of 25g to 100g a day.

Among physical symptoms experienced from such intake are muscular pain and weakness, vomiting, headaches and fatigue, and menstrual disruption.

The active ingredient in licorice, glycyrrhizinic acid, comes from the juice of the roots of the perennial leguminous herb, *Glycyrrhiza glabra*, found particularly in southern and central Europe.

The "licorice block juice" content in New Zealand licorice confectionary varies from 1% to 2.45%, but it is generally believed that stronger mixtures are available in other countries.

There is no shortage of claimed beneficial effects from licorice. One variety on sale in New Zealand shops — "Granny's Assorted Liquorice" — offers this summary:

"Liquorice was used by the Greeks and Romans for coughs, colds, and sore throats, by the armies of Alexander the Great to allay thirst and hunger, by the Chinese for strength and endurance, was believed by the ancient Hindus to increase sexual vigor and was a favorite of the Egyptian Pharoahs. Ask any grandmother and she will tell you of the medicinal properties and laxative effect of liquorice."

Paraphernalia ban stands, rules US Supreme Court

WASHINGTON — State and local bans on sales of paraphernalia for illegal drug use are not unconstitutional, the United States Supreme Court has ruled in a unanimous decision.

The decision applied to sale of items by a record store in Illinois, but relates to dozens of other ordinances which have been struck down by lower federal courts.

Justice Thurgood Marshall, who wrote the opinion, threw out the contention the sale of drug paraphernalia is protected by the "free speech" guarantee in the Constitution. "The ordinance is expressly directed at commercial activity promoting or encouraging illegal drug use. If that activity is deemed 'speech' then it is speech proposing an illegal transaction, which a government may regulate or ban entirely."

Drug stimulus a bogus path to artistic vision

By Wayne Howell

There is an interesting letter in the Feb, 1982 issue of **The Journal** from Vancouver resident Doug Hockley. Mr Hockley was responding to an article in the Oct, 1981 **The Journal** about reformed, alcoholic novelist Donald Newlove's disavowal of alcohol as a stimulus to literary art.

On the contrary, wrote Mr Hockley, alcohol and other mood-altering chemicals have been the biochemical stimulation for most major literary works throughout history. Consciousness-altering experiences, he said, "crack through inescapable dimensions and are immeasurably motivating." Writers who have used biochemical stimulation are "insightful beyond the realm in which most non-addicted mortals write," and are "fictional explorers of man's existentialism."

I hope I have not done Mr Hockley's ideas an injustice by compressing them in this fashion. I take them seriously. But that is not to say that I agree with them.

Mr Hockley's letter prompted me to speculate about the relationship of the production of art — all art, not just literary art — to altered states of consciousness. (Note that I said the production of art, not the appreciation of it). And it occurred to me that perhaps Mr Hockley's belief in the virtue of, even the necessity of, consciousness-altering drugs in the production of literary art arises because his definition of normal consciousness is too narrow and traditional.

It appears to me that all truly-great artists have a singular vision that sets them apart from the common herd. Their consciousness is already "altered" to a certain extent. For instance, most great composers tend to hear certain sounds, or feel certain rhythms, that are unique to them. You can listen to the early "Rienzi," or the late Ring Cycle and you will always hear the same thing: Wagner being "Wagnerian." Of Bruckner, another great German romantic composer, it was said in jest, "Bruckner didn't write nine symphonies, he wrote one symphony nine times." Individual painters and sculptors also tend repeatedly to manifest their own particular, or peculiar, visions: El Greco, Marc Chagall, and Alberto Giacometti come to mind. Poets and novelists tend to worry the same themes throughout the course of a lifetime; F. Scott Fitzgerald's obsession with the loss of youthful romanticism is a classic example.

From whence come these singular visions? According to neurobiologists, who are discovering new endogenous psychoactive chemicals in our brains almost daily, all our brains are bathed in a chemical soup of sorts. When the seasonings of this chemical soup become unbalanced, we too become unbalanced, in the sense that our state of consciousness becomes altered.

Most neuropharmacological research is directed at attempting to discover what type of unbalanced soup leads to schizophrenia and other psychotic illnesses, with the hope that the modern chef-physician will then be able to add a pinch of this, or a pinch of that, to stablize, normalize, or *standardize* the consciousness. But what is the normal brain soup — is it Campbell's, Aylmer's, or Lipton's?

What about "homemade" soups, which come in infinite variety? The neuropharmacologists know no more about what constitutes the outer limits of "normal" for this soup than do the biochemists know the real, minimum daily requirements of certain vitamins.

I think it is probable that there is much more variety in the standard soup than we think, and those people with an artistic sensibility and a personal vision arising out of that sensibility may be blessed, or cursed (think of Van Gogh and Sylvia Plath), with some extra and exceptional spice. Not enough to alter their consciousness to the point where we are no longer able to relate to what they produce — just enough to make us sit up and take notice of, and pleasure in, their uniqueness.

Let me switch metaphors in mid-stream and put it another way: perhaps there is a sort of bell curve of human, artistic sensibility, and the curve tails off at both ends into madness. Each of us has his own, personal vision of the world according to his or her position on the curve. The majority of us are at the centre of the curve, which is the most boring place to be. That is why we are always tantalized or fascinated by the personal visions elaborated by people seemingly further out from the centre. Those personal visions (say the visions of Jackson Pollack or John Coltrane) may strike one as a little "far out" at times, but they are never so far out that they fail to strike a responsive chord within us, if we are willing to make more than a perfunctory effort at understanding.

Since the artist probably has a unique, or "altered" consciousness he does not need external, chemical aids to make his personal vision manifest. That is not to say that he will not experiment with them, since the serious artist is, by temperament and training, closer to cracking through those "inescapable dimensions" to which Mr Hockley refers than most of us will ever be. Too often, he subscribes to the romantic notion that so many of us do — that exogenous chemicals will unlock heretofore hidden, endogenous mysteries. I think it is just that: a romantic notion.

Mr Hockley's not-unpoetic description of consciousness-altering experiences which "crack through inescapable dimensions and are immeasurably motivating" struck a chord in my consciousness (which is located, I fear, at or near the boring centre of the aforementioned hypothetical curve) and made me think of Samuel Taylor Coleridge and the opening lines of the poem *Kubla Khan:*

In Xanandu did Kubla Khan
A stately pleasure-dome decree:
Where Alph the sacred river, ran
Through caverns measureless to man . . .

Pretty stuff, I'll grant, but I'm going to use it to prove my point. That poem was written under the influence of opium, and Coleridge published it "as a psychological curiosity rather than on the ground of any supposed poetic merits."

The Coleridge poem that most cogently explores "man's existentialism," to use Mr Hockley's phrase, is *The Rime of the Ancient Mariner*. That haunting ballad was begun in collaboration with Wordsworth as the two poets were strolling in tho English countryside in November 1797, far from the opium parlors of London and Paris. There are famous lines from that poem that are used as a common metaphor by people who have never heard of Coleridge. They go like this:

Instead of the cross, the Albatross
Around my neck was hung.

The artist has a special consciousness. He needs an environment that will allow him to express his personal vision, but he no more needs external stimulants, depressants, or hallucinogens, than a meadowlark needs a musical score in front of it before it can sing its song. Drink, and drugs, have been an Albatross around the neck of too many fine artists, literary and otherwise. I don't think that makes it any easier to crack those "inescapable dimensions" of which Mr Hockley speaks.

NEWS

Radioactive particles, tar, act together

Radioactivity in cigarettes factor in lung cancer

By Pat Ohlendorf

BOSTON — Radioactivity in cigarette smoke may account for 50% of the lung cancers caused by smoking, two Massachusetts medical researchers suggest.

People who smoke 30 cigarettes a day expose their lungs to radiation equivalent to 300 x-rays each year, Thomas Winters and Joseph Di Franza write in the *New England Journal of Medicine* in February.

The radiation comes from uranium in soil and in phosphate fertilizers used in the tobacco fields, the authors say. It's in the form of alpha particles emitted by polonium-210 and lead-210, which are unstable elements in the decay chain from radioactive uranium to lead.

"When you smoke, you vaporize the radioactive particles in the tobacco and make them insoluble. They won't get into the body fluids and get carried away," Dr Winters told **The Journal**.

"They just sit there in the tender lining of the lung, radiating the bronchial cells for years. That's the big hazard."

(The half life of polonium-210 is 138 days and that of lead-210 is 22 years.)

Radiation and tar act together to cause lung cancer, Dr Winters believes. "The alpha particles initiate the cancer. The radiation scratches the cells and damages or destroys them. Then, ultimately, tar, the chemical carcinogen in cigarettes, contributes too. They act as co-carcinogens."

Passive smokers may also be at risk, Drs Winters and Di Franza contend. In their letter to the *New England Journal of Medicine*, they point to evidence that 75% of the alpha activity of cigarette smoke goes into the air, where it can enter the lungs of others.

"There's never been a really good study on the passive smoker," says Dr Winters. "Is radioactivity one of the reasons non-smokers can end up getting lung cancer? The same sort of study that linked cigarettes to lung cancer 20 years ago should now be done on the passive smoker."

Drs Winters and Di Franza did not carry out the original research leading to their recent article. Rather, while reviewing the literature during a study related to health and occupational hazards, they came across studies on cigarettes and radiation done in the early 1960s. These studies have received little attention.

"People seem to be a lot more conscious of radiation today than they were in the 60s," Dr Winters told **The Journal**. "Now is the time, I think, that this work will stimulate more research."

Although viruses may be one contributing factor to cancer, "this current theory isn't the answer entirely," he says.

"I think people will now start looking at the environmental pollutants and toxins. Radioactive alpha particles are clearly one such pollutant that research should focus on."

Since the 1960s, however, some fertilizer companies have switched from phosphates to phosphoric acid, says Dr Winters.

"Fertilizer people from the south told me recently that in converting phosphate fertilizers to phosphoric acid, about 90% of the radioactivity has been removed. That's word of mouth, though. I don't know that for a fact."

But, he maintains, because of previous use of phosphate fertilizers and because of the make-up of most soils, uranium is still present. Ultimately, radioactive particles get concentrated in the hairs of the tobacco leaf.

Radioactive particles also enter food, Dr Winters says, but there they pose less of a hazard.

"These radioactive materials are soluble in the food we eat. You take them into your body but they are excreted fairly rapidly."

Will drawing attention to radiation in cigarettes affect tobacco companies? Dr Winters: "The tobacco companies should constantly look at the phosphate fertilizers they put on their crops to increase yield. But I doubt that they will. Since they've never even admitted cigarettes cause cancer, I imagine they'll just brush this off, too."

Dr Winters is an assistant professor of medicine at the University of Massachusetts, a researcher in the area of occupational health and safety, and a practising specialist in internal medicine.

"All doctors spend a lot of time dealing with people who have diseases associated with smoking — heart disease, chronic lung disease, lung cancer, and cancers of many other organs, which are now being traced to cigarette smoking," he told **The Journal**.

"As a doctor, I can use the evidence that radioactivity occurs in cigarette smoke as a better lever in educating my patients to stop smoking."

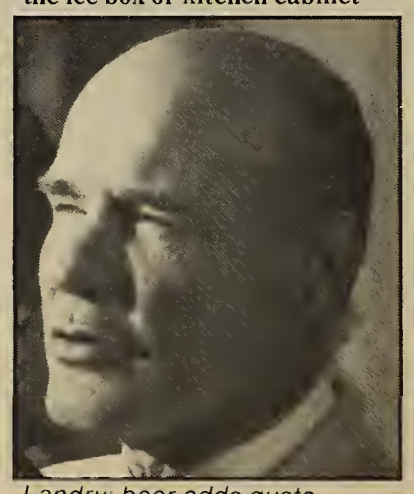
Cowboys' coach chides industry for alcohol ads

AUSTIN, TX — Dallas Cowboys coach Tom Landry says he would like to counteract the association between drinking and sports presented in alcohol advertising.

"They do glamorize it — you're not living with gusto and all the rest unless you have a beer," Mr Landry said.

He was speaking at the kick-off in February, of a statewide youth alcohol-abuse prevention effort by the Texas Commission on Alcoholism. The campaign is part of the 1982 alcohol-abuse prevention campaign by the United States National Institute on Alcohol Abuse and Alcholism (NIAAA).

Mr Landry said: "The number one drug of choice and abuse among our children today is not rolled in a paper, not bought in an alley, but is often found in the ice box or kitchen cabinet — that drug is alcohol."



Landry: beer adds gusto.

In 1980, more than 18,000 Texans aged 17 years and under were arrested for alcohol-related offences — 1,697 for DWI (driving while intoxicated), 4,623 for liquor law violations, and 11,802 for drunkenness. Six of the drunk-driving arrests were of children under 10 years, as were five liquor law violation arrests, and 41 drunkenness arrests.

State Representative Frank Madla, a San Antonio Democrat, also spoke as chairman of the House subcommittee on Alcohol and Drug Abuse among Texas Youth. He called for public input to a series of subcommittee hearings throughout the state, and he suggested legislative recommendations are likely to result from the hearings.

RESEARCH UPDATE/ Austin Rand

Smoke perils underestimated

Few students preparing for the health profession are smokers, but many don't appreciate the significance of smoking as a health hazard, indicates a study of senior-year students in health courses at the University of Toronto (U of T). Dr Mary Jane Ashley of the U of T's department of preventive medicine and biostatistics found that pharmacy students were least likely to smoke (1% were current smokers), followed by nursing (3%), physical and health education (4%), medicine (7%), dentistry (8%), and physical and occupational therapy (11%). More than 80% of the students said they had never been smokers. However, Dr Ashley found also that there was "a clear lack of appreciation for the etiologic significance of smoking: in general, students of medicine were most aware of the major nature of specific relationships (to a variety of diseases), while students of pharmacy and physical and health education were least so." Recognition of the role of smoking in lung cancer was best appreciated — but even so, 10% of nursing students, 13% of physical and occupational therapy students, and 26% of physical and health education students did not believe smoking was a major factor in the disease.

Preventive Medicine, 1981, v.10: 645-654

Caffeine/tranquillizer link?

Heavy caffeine use is likely to be accompanied by use of minor tranquillizers, suggests a study of 124 patients hospitalized for physical ailments, and 81 psychiatric patients. The authors scored both groups on total, daily caffeine intake from tea, coffee, cola drinks, and medications, and then divided the patients into three groups of caffeine-users: high (750 mg/day or more), moderate (250 mg/day to 749 mg/day), and low (0 to 249 mg/day). When caffeine use was correlated with use of minor tranquillizers (principally benzodiazepines such as diazepam) it was found that 65% of the patients with high caffeine consumption had used minor tranquillizers, compared to only about 35% of the moderate and low caffeine consumers. Psychiatric patients and those with physical ailments had a similar pattern. Part of the reason for the strong relationship between high caffeine use and use of minor tranquillizers might well be — the authors say — that some of the caffeine-craving patients were being treated for symptoms of caffeinism, the principal sign of which is anxiety.

Am J of Psychiatry, 1982, v. 139:132.

Vitamin C levels lowered

Alcohol impairs absorption of ascorbic acid, indicates a study of blood levels of ascorbic acid following a two-gram dose. The study, carried out at Deakin University, Australia, found that the two grams of ascorbic acid produced a much higher, and more-sustained rise in blood levels of the vitamin when it was taken with a typical breakfast than when taken with a breakfast accompanied by 35 grams of alcohol as a chaser. When no alcohol was given, it took at least four days for the blood level of ascorbic acid to drop to the level reached within one day when alcohol was used. "These findings indicate," the researchers conclude, "that ethanol may reduce the availability of ascorbic acid from food and predispose to ascorbic acid deficiency."

Am J of Clinical Nutrition, 1981, v.34: 2394-2396.

Smoke/drink habits studied

A British study of the smoking and drinking habits of more than 7,000 men from across the socio-economic spectrum has brought out some curious relationships between the two indulgences. Smoking status provided a fairly good basis for predicting the likelihood that the man was a moderate-to-heavy drinker. The percentage of such drinkers among non-smokers was 34%, compared to 41% among pipe or clay smokers, 47% among ex-smokers, 51% among light smokers, 55% among moderate smokers, and 62% among heavy smokers. (Moderate smoking was defined as 20 cigarettes per day; heavy, as more than 20.) However, using drinking status to predict moderate-to-heavy smoking was more difficult. The lowest proportion of moderate-to-heavy smokers was found among the white-collar, frequent, light drinkers — only about 9% of them smoked 20 or more cigarettes a day. Comparisons with other white-collar workers showed that 13% of non-drinkers, 15% of infrequent light drinkers, 20% of moderate drinkers, and 35% of heavy drinkers had a cigarette habit of 20 or more daily. Also, among both moderate and heavy drinkers, doing most of one's drinking on the weekend was associated with lower overall cigarette consumption.

British Medical Journal, 1981, v.283:1497-1502.

Drinking raises blood lead

Detailed information gathered in the British Regional Heart Study (the database of 7,000-plus British men mentioned above) has shown that men who drank three or more pints of beer daily had blood levels of lead 30% higher on average than did men who drank occasionally or not at all. The effects of elevated lead levels in adults are not well understood, but, in children, lead is a neurotoxin with effects on memory, learning, and psychomotor development. It has also been shown, in recent rat studies at the University of Western Ontario, markedly to reduce spermatogenesis. It has no known biological function, and is mainly excreted through the kidneys, with the liver believed to play only a minor role in its removal from the blood. However, say the authors of this article, slight impairment of liver function due to daily drinking may be the reason for the elevated lead levels in the regular drinkers' blood.

British Med J, 1982, v.284:299-301.

Nicotine hinders conception?

It is known that cigarette smoking during pregnancy increases the incidence of spontaneous abortion, development abnormalities, and small-for-dates babies, but it may also be more difficult even to *get* pregnant when one smokes, suggests this rat study. Pseudopregnancy was induced in a group of rats (the effect was achieved by stimulating the cervix with a glass rod). Once the rats' cycles had progressed to the point of egg release, they were injected with a dose of nicotine and the effects on blood flow to the uterus and the availability of oxygen within the uterine lumen or cavity, were examined. The injection of nicotine produced a sharp and sustained drop on both measures, indicating that a fertilized egg floating in the uterine cavity and preparing for implantation, or in the process of implanting itself in the uterine wall, might be deprived of the necessary amount of oxygen to carry out those jobs.

J of Reproduction and Fertility, 1981, v.63:163-168

Chew tobacco causes caries

Chewing tobaccos, whether of the pouch (loose-leaf) or plug (pressed) variety, contain sufficient sugar to allow caries-causing streptococci to flourish, lab tests indicate. (There are a number of natural sugars in tobacco and refined sugar is added during processing.) The researchers, at Temple University and the University of Pennsylvania, note the lively growth the streptococci exhibited under lab conditions is actually much less than would be likely to happen in the mouth. They say their evidence contradicts an hypothesis put forward in 1978 that mouth bacteria would be killed off by chemical components of tobacco, including cyanides, insecticide residues, nicotines, and other alkaloids.

Journal of the American Dental Association, 1981, v. 103:719-722

Smoking fad fading among Winnipeg kids

By Austin Rand

TORONTO — In grades 7 through 12 in Winnipeg schools, 60% of smokers are girls, indicates a recently-published study surveying Winnipeg students' smoking habits between 1960 and 1980.

The study shows that while smoking by students of both sexes has declined since the late 1960s, the decline among boys has been much steeper.

The study, headed by James B. Morison, registrar of the College of Physicians and Surgeons of Manitoba, sums up surveys conducted in 1960, 1963, 1968, and 1980, covering a majority of students in grades 5 through 12 in the Winnipeg School Division in those years. In 1980, for example, nearly 19,000 students were surveyed.

In all the surveys, response was anonymous, a fact which, the researchers note, should contribute to validity.

In the lowest grades — 5 and 6 — the proportion of boys reporting they smoked regularly was 5% in the early 1960s. The figure rose to 7% in 1968, and dropped to 4% in the most-recent survey.

A similar pattern was evident among girls in those grades. Two per cent claimed to be regular smokers in the early 1960s. This rose to 7% in 1968, and then dropped to 4%.

In junior high school — grades 7, 8, and 9 — roughly 30% of boys claimed to be smokers in the 1960s, compared to only 15% in 1980.

Among girls in junior high, the figure rose rapidly in the 1960s to a peak of 29% in 1968, and then dropped to 23% in 1980.

Data from the senior grades — 10 through 12 — show that while roughly 45% of boys smoked during the 1960s, only 25% said they did in 1980. Among girls, on the other hand, the figure rose from roughly 30% in the 1960s to 41% in 1968, and fell back to 34% in 1980.

"This is the first survey that I know of that has shown some drop in girls' smoking, as well as the well-known decline in boys' smoking," Dr Morison told **The Journal**. He said the recent US Surgeon General's report, (see page 7), "showed much the same kind of trend. The girls are starting to follow the boys — they are just one step behind them."

Dr Morison also provided **The Journal** with some so-far-unpublished material, drawn from the same surveys, dealing with changes in the proportions of students who had "never smoked a cigarette."

This material indicates that experimentation with cigarettes is on the decline.

For example, in junior high school, the proportion of boys who said they had never smoked jumped from 23% in 1963 to 57% in 1980. The figures for junior-high girls showed a similar trend from 44% in 1963 to 48% in 1980.

Among senior boys, the "never smoked" figure jumped from 18% to 49% when those years were compared, and from 27% to 36% among senior girls.

"These are encouraging figures," Dr Morison said. "I think they point to something that we see all around us. Smoking is just becoming out-of-fashion."

The Winnipeg surveys have also shown that mothers are more important than fathers in the smoking example that they set for their children, particularly for their daughters.

Among girls with only a smoking mother, 30% were more likely to become smokers than those with a smoking father.

GILBERT

. . . At $2.50 per pack, cigarettes in Ontario would still cost less than they do in Denmark and Norway . . .'

A sure way to reduce cigarette use

By Richard Gilbert

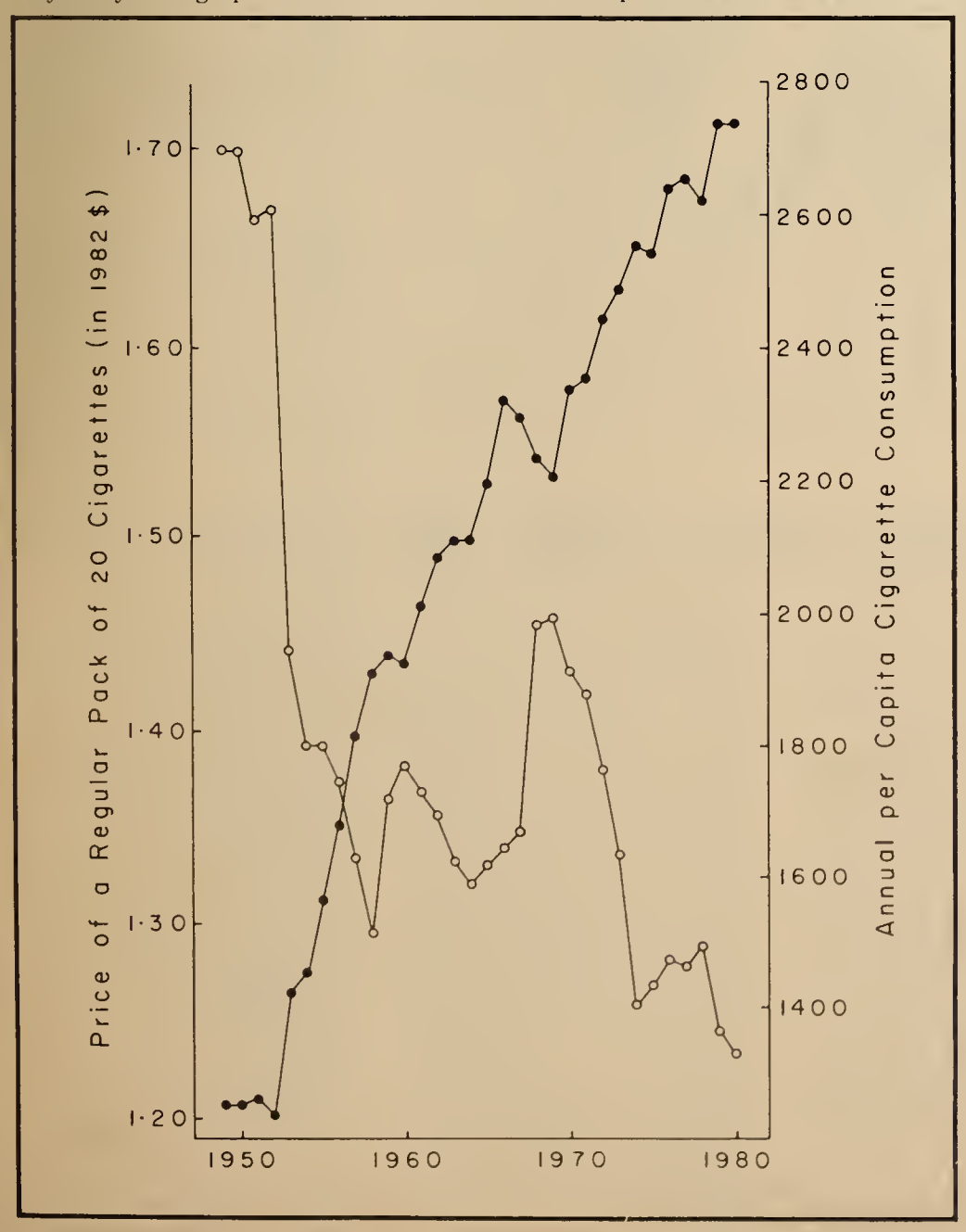
The two graphs below show how cigarette consumption by Canadians has changed since 1949 (filled circles), and how the price of cigarettes has changed in constant dollars (open circles). In 1949, there were 1,252 cigarettes bought in Canada for every man, woman, and child. The average price per pack was the equivalent of $1.70 in today's money. In 1980, average consumption was 2,739; average price was $1.23 in 1982 dollars.

Thus, on the face of it, there seems to be some kind of relationship between price and consumption — the lower the price, the more cigarettes are purchased per capita and, presumably, used.

Elasticity

Careful examination of the data portrayed by the graphs shows that the closest relationship is between *changes* in real price and *changes* in consumption. During the period 1949 to 1980 a 1% increase in price was associated on average with a 0.7% decrease in consumption. In the jargon of economics (more precisely, econometrics) this is the same as saying that the real price elasticity of demand for cigarettes was -0.70.

Falling prices have likely been a cause, rather than a consequence, of the increased consumption. It follows that cigarette use could be reduced by raising the price. Specifically, if government were to raise taxes on cigarettes in such a way as to cause a 10% increase in their real price, consumption would fall by 7%.



Hand-rolled cigarettes

In most places, including Ontario, taxes on tobacco products are seen as a means of raising revenue and not as a means of curbing cigarette use. Nevertheless, there is a fairly strong, negative correlation between the consumption and the price of cigarettes in various countries with similar economies. Prices are relatively low in Japan, the USA, Canada, and Switzerland, in all of which annual consumption is more than 2,500 cigarettes per capita. Prices are relatively high in Scandinavian countries, where annual consumption is below 1,500 cigarettes per capita.

Norway has the highest prices (currently more than $3 a pack) and the lowest per capita consumption of manufactured cigarettes (less than 500 a year) among countries I surveyed. More hand-rolled than manufactured cigarettes are smoked in Norway, because they were once much cheaper and smokers acquired a taste for them; but even including hand-rolled cigarettes, Norway's consumption is still very low.

In both Britain and West Germany, cigarette taxes have been increased recently, not only to raise revenue, but also to curb consumption. If price elasticity is between 0 and -1, as it has been found to be in most studies, raising prices can achieve both things. A tax and price increase of 10% that reduces sales by 7%, for example, will increase revenue to government by 2.3%.

Cigarette prices have been pushed up by more than 25% in real terms in both Britain and West Germany during the past year, with resulting declines in consumption of more than 15%.

Taxes

Even larger price increases can be contemplated, with consequently larger cuts in consumption. A realistic objective for Ontario might be to reduce cigarette use by half in this way. The reduction could be achieved over the course of a year by means of three, equal price increases, made at four-month intervals, that together would double the price. At $2.50 per pack, cigarettes in Ontario would still cost less than they do in Denmark and Norway.

At present, the $1.25 price of a pack of cigarettes is made up in the following way:

Tobacco grower / Manufacturer	23¢
Wholesaler / Retailer	38¢
Provincial tax	33¢
Federal taxes	31¢

If only the provincial tax were raised, in order to reduce consumption, federal revenue would fall. Thus, it is likely that if one government were to propose a huge tax hike, the other one would want to do the same. If both raised their taxes by about 150%, and production and marketing costs per unit increased by about 50% in response to the cut in output, the components of the $2.50 pack of cigarettes would look like this:

Tobacco grower / Manufacturer	35¢
Wholesaler / Retailer	57¢
Provincial tax	81¢
Federal taxes	77¢

Taxes would then amount to 63% of the price rather than the present 51%. In many European countries, taxes account for well over 70% of the retail price.

Provincial and federal governments now collect $665 million annually in revenue in respect of taxes on cigarettes sold in Ontario. Revenue would rise by 23% to $821 million if taxes were raised by 150%, and consumption fell by half.

Thus, almost everyone would benefit, at least in the short term. Smokers would be healthier, because they would smoke less or quit. Governments would be richer from increased revenue and reduced medical costs. They would be able to afford retraining for displaced workers in the tobacco industry and incentives for tobacco growers to switch to peanuts. Taxpayers generally might benefit from reduced taxes.

Costs

In the long term, costs might mount again. People would live longer, on average, because fewer would die prematurely from tobacco-related diseases. Pension funds would require buttressing from general revenue, operating costs for homes for the aged would increase, and the medical profession would prosper from the growing need for geriatric care.

The main short-term disadvantage in raising cigarette prices is that bootlegging would increase. A lot already goes on between higher-price American states, such as New York, and low-price states, such as North Carolina. A 15% tax increase by the Canadian federal government in 1950 was repealed soon after because of the resulting growth of illegal United States' imports. Today, borders are better managed. Better surveillance for smuggled cigarettes might be a small price to pay for a society that is freer from disease.

Next month: Another sure way of reducing cigarette use.

NEWS

Health hazards of cannabis justify intensified study, says expert team

By Harvey McConnell

WASHINGTON — Marijuana produces such a broad range of psychological and biological effects that its use justifies serious concern, says the latest United States government report on marijuana and health.

The report was issued by the Institute of Medicine of the National Academy of Sciences, which undertook the study, and follows hard on the heels of a report by the Addiction Research Foundation (ARF) and the World Health Organization (WHO) which reached similar conclusions.

The report by the Institute of Medicine said scientific evidence to date does not show how serious some risks can be.

"Our major conclusion is that what little we know for certain about the effects of marijuana on human health — and all that we have reason to suspect — justifies serious national concern.

"Of no less concern is the extent of our ignorance about many of the most basic and important questions about the drug.

"Our major recommendation is that there be a greatly intensified, and more comprehensive program of research into the effects of marijuana on the health of the American people."

Marijuana is now the most widely-used, illegal drug in the US: by 1979, more than 50 million people had tried it at least once.

There has been a slowdown in use among high school seniors. While more adolescents have used alcohol than marijuana, among seniors, more use marijuana on a daily basis.

Dr Harold Kalant, of the ARF and University of Toronto, was among the select committee which drew up the report. Many committee members attended the ARF/WHO conference and access to all documents presented at the Toronto conference was provided to the committee.

Other Canadian contributors to the study included Dr Ellen Dempsey, McGill University; Dr Kevin Fehr, ARF; Dr Oriana Kalant, ARF; Dr Arthur Zimmerman, University of Toronto; and Dr F. Clarke Fraser, Montreal Children's Hospital.

On the possible effects of marijuana use, the report said: "We can say with confidence that marijuana produces acute effects on the brain, including chemical and electrophysiological changes. The most clearly-established, acute effects are on mental functions and behavior."

There is no conclusive evidence as to whether prolonged marijuana use causes permanent changes in the nervous system, or sustained impairment of brain function and behavior in human beings.

Long-term effects on the brain and on behavior remain to be elucidated. "Although we have no convincing evidence thus far of any effects persisting in human beings after cessation of drug use, there may well be subtle but important physical and psychological consequences that have not been recognized."

The report said marijuana smoke is a complex mixture and suggests "the strong possibility that prolonged heavy smoking of marijuana, like tobacco, will lead to cancer of the respiratory tract and to serious impairment of lung function."

About effects on the reproductive system, the report said that Δ^9 THC (tetrahydrocannabinol) appears to have a modest, reversible, suppressive effect on sperm production but there is no proof of a deleterious effect on male fertility.

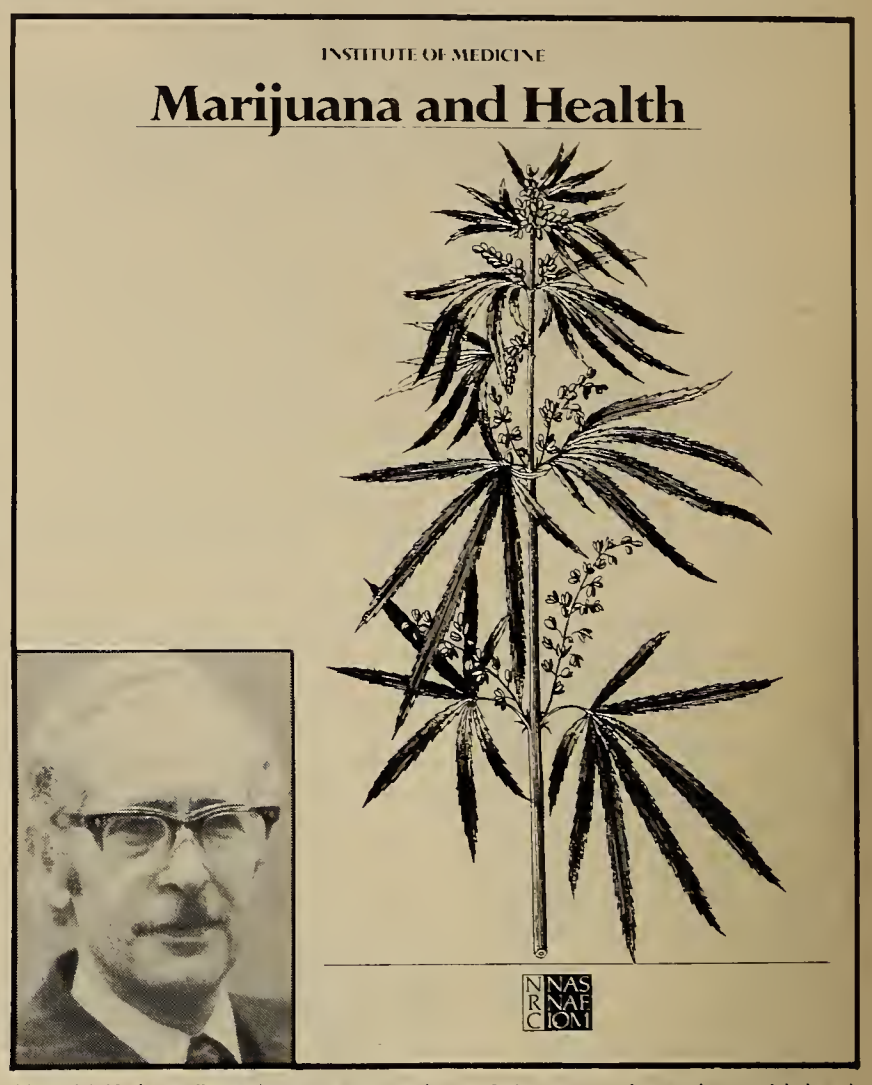
Effects on human female hormonal function have been reported, but the evidence is not convincing. However, there is convincing evidence marijuana interferes with ovulation in female monkeys.

The committee examined the possible medical applications of marijuana derivatives in a variety of conditions, and concluded more work is needed.

In addition, "because marijuana and Δ^9 THC often produce troublesome psychotropic or cardiovascular side effects that limit their therapeutic usefulness, particularly in older patients, the greatest therapeutic potential probably lies in the use of synthetic analogues of marijuana derivatives with higher ratios of therapeutic to undesirable effects."

Members of the committee criticized the lack of adequate research and the paucity of US federal funds which have gone into such investigations.

"The committee considers the research particularly inadequate when viewed in light of the extent of marijuana use in this country, especially by young people. We believe there should be a greater investment in research on marijuana, and that investigator-initiated research grants should be the primary vehicle of support."



Harold Kalant (inset), was a member of the committee that criticized lack of funding for marijuana research in the United States.

'Anti-sniff' bylaw reversal upsets city officials

By Peter Unwin

WINNIPEG — After three years of court battles, Winnipeg's so-called "anti-sniff" bylaw, controlling the sale of sniffable solvents to juveniles, has been quashed by the Manitoba court of appeal.

The bylaw, spearheaded by the Anti-Sniff Coalition, a local citizen's group, was implemented in 1979. It stated that no intoxicating substance, ranging from contact cement to lighter fluid, could be sold from a self-service counter. It further stipulated anyone under the age of 18 who bought the product must produce a written note from a parent containing the parent's signature and address. The store was required to keep the note on file for six months.

The bylaw also provided safeguards against shoplifting by requiring that any container of sniffable solvents under one litre be kept away from a self-serve counter.

The legislation was challenged when a local Zellers store was charged for making a sale from such a counter. In the court case, a judge ruled the bylaw was invalid, saying Winnipeg city council had no right to pass the legislation because it intruded on the field of criminal law, which is outside the powers of municipal government.

The Zellers decision was appealed by the Crown to the county court of Winnipeg. County court judge C.I. Keith allowed the appeal, which left Zellers facing up to a $5,000 maximum fine, provided for in the bylaw (**The Journal**, Dec, 1981).

Zellers then took the case to the Manitoba Court of Appeal, which in a Feb 19 decision, reversed the ruling of the lower court. The department store was acquitted, and the bylaw quashed.

Staff Sergeant Bill Evans, of the Winnipeg police department, who was responsible for laying the charge, expressed disappointment ove the ruling.

"We were very happy with the hylaw," he said. "It spelled out exactly when an officer could lay a charge."

While he admitted it was virtually impossible to stop the sale of household chemicals for intoxicating purposes, he considered the law was at least making it a little harder.

Though the bylaw is no longer in existence, Sergeant Evans said the majority of storeowners are still upholding it by keeping "sniff" away from accessible store counters.

"We're finding that a large number of businessmen are abiding by the old law," he said. "They've been damn good about it."

The head of the Anti-Sniff Coalition, Don Macri, was also enthusiastic over the merchants' actions.

"We've had good voluntary cooperation from them," he said. "Some of them just didn't know about it, about who was taking it, or the consequences."

But Mr Macri was disappointed by the reversal. "There is not a law in Canada which controls the distribution of solvents," he said. "It's a free game.

"The bottom line for a citizen's group like ours is that it makes us wonder if the city has any power at all. It seems only the parliament of Canada has the power to pass this legislation, but they're not interested, and they're not interested in letting us do it, either."

The Manitoba Department of Attorney Generals has decided not to pursue the Winnipeg Anti Sniff Bylaw to the Supreme court of Canada, says the office of the Director of Criminal Prosecutions.

Program steers around non-compliance problem

Denver devises plan for alcoholics with TB

DENVER — A therapy designed to increase the effectiveness of treating alcoholics with tuberculosis, has been established at Denver General Hospital.

The program is an attempt to overcome a common problem with alcoholic patients — non-compliance and effective follow-up. Powerful anti-tuberculosis drugs are used to reduce the treatment period from nine months to six months.

The thrust of the regimen, Michael Iseman told **The Journal**, "has been not only to reduce the treatment period . . . but to be able to give the treatment intermittently."

At Denver General, patients get only two weeks of in-hospital, daily therapy. For the next five-and-a-half months, they are treated in the clinic twice-weekly to ensure they take their medication.

Although experimental, the new treatment plan is working well, Dr Iseman said. Patients' sputum is rapidly converting to negative where the tuberculosis bacillus is concerned. The alcoholics in the treatment plan have not suffered further damage to their livers from the drugs.

"Our dilemma was that it is indeed the alcoholic patient who's most likely to be non-compliant," Dr Iseman told a tuberculosis-management course sponsored by the National Jewish Hospital.

"So if we derived a regimen that was very effective, but that would not be tolerated by alcoholics, we would not have answered our problem. A typical profile of many people with tuberculosis these days is that they are alcoholic, so if our treatment is to be broadly employable, it must be tolerated by alcoholics."

Dr Iseman said "there was a great concern because we were using three drugs which have a history of possibly injuring the liver, and we were leery of this. But our concerns were substantially answered by large trials conducted elsewhere in the world in large numbers of patients, including many alcoholics with underlying liver disease, and there was tolerance to these drugs — Isoniazid, Rifampin, and pyrazinamide (Tebrazid)."

What remains to be determined, he said, is whether the patients will remain cured, two to three years after their treatment has stopped.

Dr Iseman expects the six-month treatment plan will be less costly than the usual nine-month therapy with the drugs Isoniazid and Rifampin.

He said even with a twice-weekly regimen for only five and a half months, instead of eight, there is still the problem of getting the alcoholics to come in to the clinic.

"We offer them various inducements, including free bus tokens," Dr Iseman said.

"We also provide additional medical care for non-TB problems for free as an additional inducement. We provide baby sitting in the clinic for mothers who come in with their children. We have done everything we can to make it possible for the patient to come in, and we feel that in going half-way like this, we pretty much tell the patient that we care about them and that we're serious about seeing that he or she is successfully treated."

NEWS

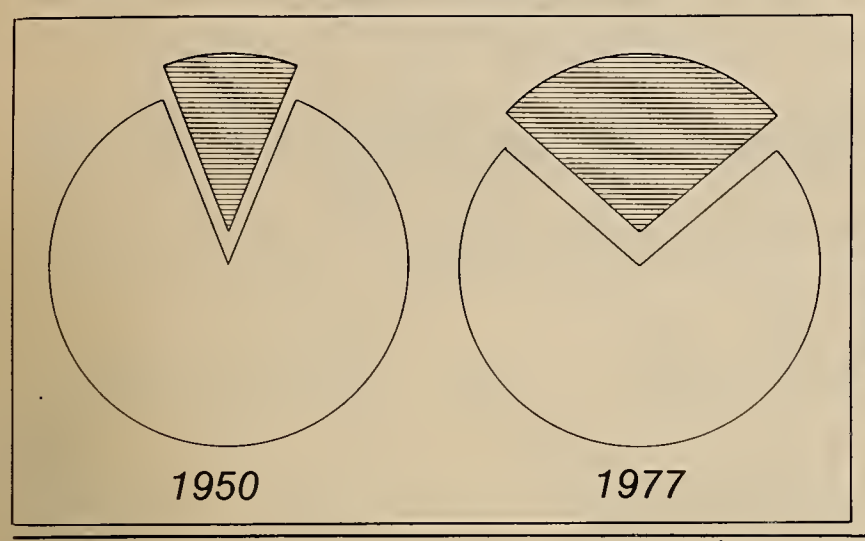
Smoking is 'chief preventable cause of death'

US sur-gen zeroes in on cancer

WASHINGTON — The most serious indictment yet made against cigarette smoking has been issued by the United States government.

This is the report of US Surgeon General Everett Koop, who said the latest study by the public health service shows "cigarette smoking is clearly identified as the chief, preventable cause of death in our society."

Because cigarette smoking is so linked with cancer deaths, the latest report was devoted entirely to this subject. However, Dr Koop said, this should not distract attention from the even larger costs of deaths from coronary heart disease, chronic lung disease, and other ills traced to cigarette smoking.



From 1950 to 1977, the percentage of deaths due to cancers of the lung, larynx, oral cavity, and esophagus, more than doubled. The chart doesn't include deaths from cancers of the bladder, kidney, and pancreas, some of which can be attributed to smoking.

The decision to focus on cancer was made for several reasons: it has been associated with cigaretts for more than 50 years; cancer is the second most frequent cause of death in the US; and, while death rates for other conditions have fallen in recent years, those for cancer remain high, and this is due almost solely to cigarette smoking.

The report said that smoking is a major cause of lung, larynx, oral-cavity, and esophagus cancers, and a contributory factor in the development of cancers of the bladder, pancreas, and kidney.

Excess mortality has been found among cigarette smokers for cancers of the stomach and uterine cervix, but evidence available is deemed insufficient for conclusions about the nature of the association.


Koop: many other diseases also caused by cigarette smoking.

The report notes that in the case of passive smoking, studies show evidence of elevated carcinogenic risk among non-smokers exposed to the smoke of smokers.

Dr Koop pointed out in presenting the report that if it were not for the smoking-linked deaths the overall cancer mortality rate in the US would have fallen. In contrast, survival time for cancers not associated with cigarette smoking, such as prostatic, colo-rectal, and breast cancers, have increased.

Scots team kicks tobacco for World Cup

GENEVA — The Director-General of the United Nations' World Health Organization (WHO), has sent a telegram to Edinburgh congratulating the Scottish World Cup soccer team for giving up smoking.

The move is intended, indirectly, to support pressure groups in Western Europe and North America seeking to counter commercial sponsorship of popular sporting events by tobacco companies as a form of advertising that associates cigarette smoking with health.

The Scottish Association football team is to participate in the 1982 World Cup competition in June as a "non-smoking" group.

The WHO chief, Halfdan Mahler, dispatched his cable after a resolution passed by the 30-member executive board of the WHO commended the Scottish team for "setting an excellent example to all participants in sport and to their supporters."

A specialist spokesman for the WHO comments: "Do top sportsmen smoke? If they do not, then they should say so clearly and loudly to help to establish healthier lifestyles for the young people who idolize them throughout the world."

The Scottish team is to be sponsored at the June games by the Scottish Health Education Group and will be extensively publicized as "the non-smoking team of the World Cup."

It happens that the countries designating members to the WHO executive board in its present composition include Spain, the host of the 1982 World Cup, as well as Brazil and New Zealand whose soccer teams are to be grouped together with the Scottish team in the preliminary stages of the games.


Scottish World Cup team will compete in June as non-smokers.

Dr Ernani P. F. Braga, vice-president of the Oswaldo Cruz Foundation, and director of the Brazilian National School of Public Health in Rio de Janeiro, told fellow members of the board that, both as a former football player and as a public health specialist, he would welcome the active support of sportsmen to warn young people against the hazards of cigarette smoking.

Similar sentiments were expressed by Dr John H. Hiddlestone, chairman of the board and New Zealand's director-general of health, and Professor Jose Maria Segovia, director-general of medical research at the Spanish National Health Institute.

The issue was raised by Dr John A. Reid, chief medical officer of the Scottish home and health department, Edinburgh, in connection with a resolution concerning cigarette smoking and lung cancer.

Dr Mahler's congratulatory cable said: "This is a most sensible action that health-minded, successful sportsmen could undertake, and hopefully other teams in this and other sports will follow the Scottish team's example."

Prosecutor gets tough on drunk driving

COLUMBUS — The present penalties for drunk driving are a joke," says an Ohio lawmaker, who has urged passage of legislation cracking down on drunk drivers.

William Scheneck, Greene County prosecutor, made the remark while testifying in support of measures that would give Ohio some of the toughest drunk-driving penalties in the United States.

He said current penalties are a joke, because sentences are supposed to include a mandatory three-day jail term, but are usually bargained away in exchange for the defendant's attending "several hours of some kind of education course."

Mr Scheneck said he particularly supports a provision in one bill which denies probation to people convicted of aggravated vehicular homicide.

That provision is "harsh but very necessary," Mr Scheneck said.

He also supports a provision that increases from six months to a year the period of licence suspension for drivers who refuse to submit to alcohol-content blood tests, and a provision that requires a six-month suspension for any driver found to have a blood alcohol content of 0.10% or more.

Let them have cold beer, says liquor chief

New Brunswick topples own drink records

FREDERICTON — Per-capita consumption of alcoholic beverages in New Brunswick topped the $200 mark for the first time in the fiscal year ending March 31, 1981.

The annual report of the New Brunswick Liquor Corporation (NBLC) shows that in 1980-81 total sales of the corporation were $137,801,211 — an increase of $12,389,370 or 9.88% over the previous year. Based on the June, 1981 census, the population was 688,926. This produces a per-capita consumption valued at $200.03, compared with $184.43 in 1979-80.

Beer was the most popular beverage, with 52.2% of total sales. Spirits slipped slightly to 39.3% from 40.6%, while wine showed a marginal increase to 8.5% from 8.4%.

In dollar terms, beer sales were valued at $71,886,418 — up 12.43%. Spirits totalled $54,149,905 — up 6.42%. Wine sales were $11,764,887 — up 11%.

During the year, the NBLC made special efforts to present products "in a manner which will assist the consumer. New wine racks have been designed and constructed which enable our customers to more easily select a wine of their choice," the annual report states.

Income from corporation sales was up 8.83% at $63,395,601 after provision was made for the cost of sales. After deducting expenses, the NBLC showed a net income of $48,258,143 — an increase of 8.82%. After addition of the more than $5-million balance at the commencement of the fiscal year, the corporation made payments to the province totalling $48,385,000 — up 9.09% from the previous year.

In five years the corporation has almost doubled the turnover rate of inventory. In 1976 the rate was 7.9 times, and in 1981 reached 13.7 times.

The number of stores operated by the corporation increased by two to 67. The Fredericton Mall store had the highest sales, a total of $6,709,504. Moncton's Mountain Road outlet was second, with sales of $6,069,516, and the Saint John K mart plaza store was third with $5,908,172 in sales.

As the Public Accounts Committee of the NB Legislature began study of the annual report and operations of the NBLC, opposition was raised to the corporation's plan to test sales of cold beer in four provincial locations.

Pilot stores selected for the marketing experiment are in Campbellton, because it's close to Quebec which sells cold beer in grocery stores; Shediac, to test the reception in an area of heavy tourist trade; Fredericton, as an urban area; and Sussex because, "it is an area where there are no unusual circumstances involved," says the NBLC chairman Budd Kinney.

Alfred Roussel, Liberal MLA for Restigouche East, says selling cold beer would increase consumption. He is supported by Progressive Conservative MLA William Harper (Petitcodiac), who says "cold beer is an invitation to drink on the way home or on the Shediac beach." He said the electorate should have been consulted.

Mr Kinney replies that a survey shows 65% of those who prefer beer want it cold, and it is sound business to give the consumers what they want. He warns that failure to meet consumers' desires could result in private enterprise displacing the corporation.

NZ smokers are giving up

AUCKLAND, NZ — A provisional analysis from the 1981 national census here (which for the second time included a question on smoking) shows that since 1976 the number of regular smokers has fallen to 35% from 40% among males, and to 29% from 32% among females.

The director of the National Heart Foundation, Dr David Hay, says more than 425,000 people — out of a total population of 3,195,000 — have given up after previously smoking regularly. New Zealand's smoking figures run parallel to those of the United States but are much lower than most European countries.

In all male age groups the number of regular smokers has declined. The same trend has occurred in women, except for those under the age of 24. Under this age, more women smoke than men.

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Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

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CANNABIS, HEALTH, & THE LAW

ARF should assemble a 'more definitive statement'

First, let me congratulate the foundation (Addiction Research Foundation) for publishing the pamphlet *Cannabis, Health and the Law* by John B. Macdonald, also published in **The Journal,** (Oct, 1981).

It has been of concern to me, however, that such an article could be written without any reference to, or apparent concern about, the significance of the present methods of illegal distribution of cannabis by criminal elements in our society. This results in the linking of an ordinarily non-criminal purchaser in an illegal transaction, to a "pusher" engaged in an illegal act — resulting in extensive profits to those who, at present, control the drug's distribution and sale.

In this article, the disadvantages regarding proposals for legalization of distribution and sale through government outlets are enumerated; but few of the advantages have been suggested.

Apart from major reduction in law enforcement and judicial costs, and the consequent removal of civil disqualifications arising from a criminal record, other social benefits would accrue from quality- and cost-control of the substance; removal of its distribution and control from the criminal elements and syndicates; and prevention of advertising or promotion which would eliminate the present role of the "pusher" who has a financial interest not only in promotion but, often, in encouraging progression to use of other higher-priced, and more-dangerous substances.

Fear of being accused of giving tacit approval to, or being thought to condone use of cannabis is, in effect, condoning present methods of criminal control and resulting profits to the criminal groups which, it is said, have tentacles reaching into the entire fabric of community life, including many apparently-legitimate business interests.

The suggestion that governments would be less interested in discouraging the drug's use because of the financial return that would accrue to the taxpayer, could be balanced by the prevention of all advertising or promotion of its sale. Your conclusion that "Precedent suggests that use would steadily increase," is not demonstrated, up to the present, by the data you mention from the United States. Neither is the source of the "precedent," or the data involved, mentioned in this statement which, therefore, seems to be an unsupported assumption.

Even if cannabis use did increase to some extent, allowing for population increase, the social advantages which would accrue from the removal of all criminal disqualifications should more than counterbalance the possible individual health hazards involved in casual, social use. The health of society and its social institutions must also be considered against the choice of the individual to risk using this substance.

You have asked the question: "Given the risks to health from use of cannabis, does the foundation advocate that cannabis not be used?" You have answered categorically and predictably that "the foundation advocates strongly that cannabis not be used." This is a statement that most of us would support. But it is not the most important question since, as you indicate, "in 1978 more than three-million Canadians, one-third of whom were teenagers, used cannabis."

The urgent question concerns the social and legal control of cannabis which is now under consideration by the federal government. You have given this question a rather inconclusive analysis, leaving it to the general public and the legislators to "bite the bullet," and make the decision.

The role of the researcher in both the bio-medical, and in the social, criminal, and legal fields with which you are concerned, is to obtain data and, on analysis, to present findings and conclusions as to the implications for change.

The role of the government is to rationalize such research implications into a legal and social policy structure in the best interests of the community as a whole.

It would be of great assistance not only to the legislators, but also to the general public, if your administration and the board of directors of the foundation were to make a more definitive statement indicating that, in light of present knowledge, all factors considered and on balance, the foundation recommends what it considers the most desirable course of action.

Obviously, I am deeply concerned about this problem, particularly for young people, and, because I believe many other ordinary citizens share this concern, I have the temerity to express these views.

Archibald M. Kirkpatrick
Former executive director
John Howard Society
of Ontario and of Canada
Toronto, Ont

Research on inhalants needs more attention

Your Inhalant Factsheet (**The Journal,** Nov, 1981) is certainly welcome as this distinctly separate area of drug abuse is more common, and the state of the science is a bit more advanced, than you indicate.

In the 1960s, inhalation fatalities were usually observed as suffocation from use of plastic bags because of a few cases where victims were found with their heads inside plastic bags.

In 1970, Dr Millard Bass of Johns Hopkins University reported on studies of 110 fatalities in a six-year period when the term "sudden sniffing death" was coined. He associated chemical sensitization of the heart muscles, which reacted abnormally, with in-

(See — Violence — page 12)

In his first interview since taking office, Carlton Turner (right), senior drug policy adviser at the White House, talks to Washington Contributing Editor, Harvey McConnell.

White House drug adviser finally removes veil —policy is 'very basic' and takes long-term view

WASHINGTON — Leaks are endemic in Washington, but months after arriving at the White House from Mississippi, Carlton Turner kept press and Congress alike in the dark about the thrust of drug-abuse policy under President Ronald Reagan's administration.

"It was the best, damn-kept secret in Washington," he says with a chuckle, "and there were no leaks from this office." Now Dr Turner's plans as senior policy adviser for drug policy are becoming visible.

Within a week in February, Nancy Reagan made visits to drug programs in Florida and Texas, which were covered extensively by press and television, and Vice President George Bush outlined, in Miami, initiatives the administration is taking to combat the lawlessness in Florida produced by drug trafficking (see page 1).

Later, Dr Turner outlined administration plans to the Senate subcommittee on alcoholism and drug abuse.

Dr Turner, in his first interview since taking office, told **The Journal**: "We are beginning to let the nation know that this administration is serious about the drug problem. The president's policy is very basic: law enforcement, prevention and education, treatment and rehabilitation, and research.

"It calls for a balancing of these areas with no single one given particular importance over the others. It says we have to take a long-term approach, and this knee-jerk, short-term, put-a-buck-here and put-a-buck-there, is not going to solve the problem."

Dr Turner is particularly pleased that the president, vice president, and the first lady are all involved publicly in one of the most serious problems in US society.

Nancy Reagan: 'a boost to parents.'

He believes Mrs Reagan's interest has definitely given a boost to the parents' movement. "She is a very concerned mother, and she has not just gotten interested, she had been interested in the situation for several years. She supports the president's program, and she is a very effective spokesman for prevention and education.

"I think she has helped to motivate the general prevention effort because, for the first time, we have had someone who is willing to say 'prevention can work, you parents can make a difference'."

Dr Turner is adamant the federal government should not be involved in funding the parent groups "because when you start funding something you start controlling it, and you can kill it.

'. . . There are certain international initiatives which I will not discuss now because of their nature . . .'

"The parent groups are unique, and I have never visited two groups which had the same idea about everything, but they do the job on the local level. It is the desire of the president and Mrs Reagan to stimulate these parent groups and for them to have the resources they can count on . . . ."

The keys will be the NIDA (National Institute on Drug Abuse), the NIAAA (National Institute on Alcohol Abuse and Alcoholism) and ACTION, the federal agency for volunteer work which includes the Peace Corps.

Dr Turner said the aim is to develop regional and state drug abuse volunteer coordinators who will be responsible for encouraging volunteer efforts in drug and alcohol prevention programs. ACTION has established a centre in Georgia which will provide publications and information.

Dr Turner sees both the NIDA and the NIAAA continuing their research efforts and transmitting this information to the general public in terms the layman can understand.

"For many years we scientists — and I am one of them, I can sit here and say it — we sat up in our ivory tower and we didn't want to come down. But it is time we began to communicate on a level parents can understand. We have that obligation."

Dr Turner says the emphasis is on reducing the demand for drugs in our society. "We are going into this area in combination with a lot of other things, with the idea that we can reduce the flow of drugs coming into the US, by interdiction, by arresting at the border, by trying to chase when they are out there."

International initiatives are also being taken. "There are certain types of initiatives in certain countries which I will not discuss now because of the nature of them."

Although marijuana receives the most publicity these days, Dr Turner sees alcohol use as just as important. He believes prevention must be directed primarily at school-age children, who are most vulnerable to the problems of drug and alcohol use.

Alcohol and drug use must be attacked in the context of the range of ills which threaten young people, including health hazards, deterioration of family structure, and alienation from community authority.

He sees cocaine as an awesome threat. "I think we have got a disaster now with cocaine, and we have no idea how much is here. You have a drug where people in the highest place in government have said it's no problem and don't worry about it. We did the same thing with marijuana, and now we've got a problem."

There is no question cocaine is a psychologically-addictive drug, "and people have refused to recognize the significance of a drug that is psychologically addictive. They think you have got to worry about something which is physically addictive."

Dr Turner says he is as guilty as many other Americans who in the past have indulged in what he calls the "NIH syndrome: not invented here."

As an example, he is a friend of Dr Nils Noya, the Bolivian drug expert who reported serveral years ago on extremely serious problems he had encountered with cocaine users in South America (**The Journal**, Jan, 1978), and he recalls conversations a few years ago.

"Nils would tell us about the severe problems young Americans down there, and others, were having with cocaine, and we sort of laughed at him.

"And I remember talking to some Turkish researchers a few years ago about some other drug problems, and I admit I was one of the ones that sort of laughed at them. Well, some of the things they stated categorically are hitting us right now on every front."

Dr Turner believes the sharing of information among services and agencies is vital, such as involving the military in combatting drug traffic.

"One thing I have got to say, which has always bothered me, is that when you talk about drug initiatives many people want to see three things: they want to see buildings, or a monument; they want to see dollars, and a balance sheet; and they want to see bodies.

"We need sharing of intelligence. Let us use the resources we have more effectively, and let it be coordinated between agencies, and it will work."

A long-range strategy which includes prevention and education, international initiatives, proper enforcement, and other approaches, can help reduce the demand and reduce the supply of drugs. "But we are not going to do it overnight, and we are not going to do it throwing money at it," he says.

Dr Turner, who was in charge of growing marijuana for the federal government for legal research purposes, has some strong views on certain research efforts.

"We have been trying to compare every drug with a single drug, but we would not let a pharmaceutical company do that. There, every drug has to stand on its own merits, and you can't compare this to that to get it on the market, yet we have taken one drug and compared every drug to that.

"People still don't realize that no two samples of marijuana are ever going to be the same. You have got to understand a drug and you can't understand marijuana just with delta nine THC; it is ludicrous to think that. You cannot understand the nature of a crude drug on the basis of one component.

"One thing that galls me, for example, is that we still have this notion that marijuana is the panacea for glaucoma, and it never has been. Even in rabbits (which preceded human testing) intraocular pressure changes day to day.

"People never understand. Hundreds of drugs get an IND (investigation of new drug) but never make it.

"We have done a disservice by talking about delta nine as marijuana research."

Dr Turner sees the administration's policy as a long-term effort. "We are not going to turn things around in six months."

President Reagan: 'serious about drug problems.'

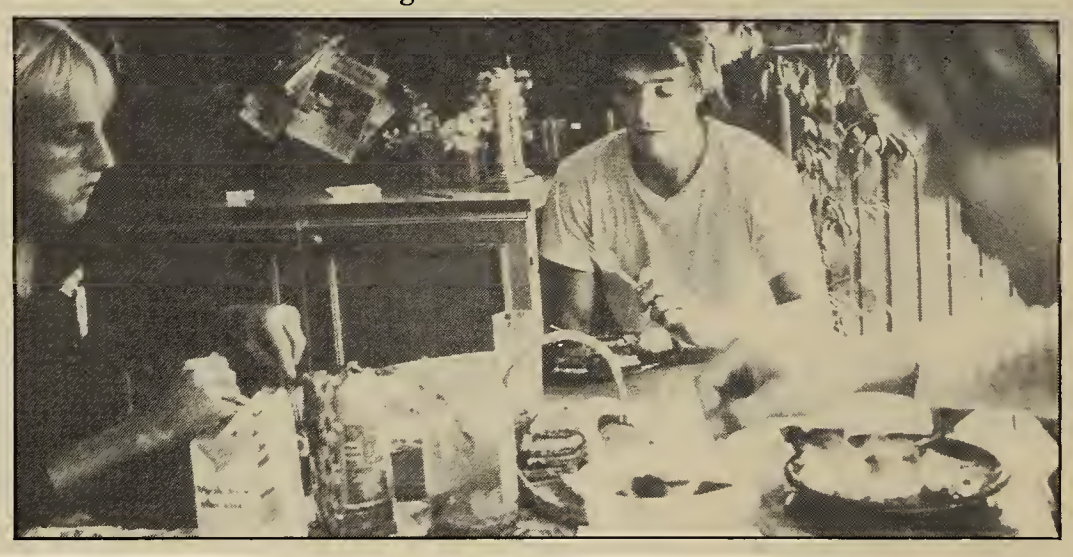
INTERNATIONAL

Family setting helps young Swedish addicts

LUND, SWEDEN — Ljungstorps farm in south Sweden provides young Swedish drug addicts with a personalized rural setting to help them deal with the rigors of drug withdrawal.

A family-care approach is intensified by an about-face in lifestyles — from drug abuse in the city, to collective living and work-sharing on the farm. Patients' activities range from logging, to housework and cleaning stalls.

Less costly than institutionalized therapy, the farm is in the southern province of Skane and records a success rate of close to 60%. The Swedish government will be discussing the possibility of creating more re-hab centres based on the Ljungstorps model.



UN drug commission elects executive

VIENNA — Giuseppe diGennaro of Italy is chairman for this year of the United Nations Commission on Narcotic Drugs. He was elected at the recent commission meeting here. He replaces Major General Chavalit Yodmani of Thailand.

First and second vice chairmen respectively are Garcia Fernandes of Argentina, and Istvan Bayer of Hungary. Maurice Randrianame of Madagascar is rapporteur.

Mr diGennaro has also been appointed executive director of the United Nations Fund for Drug Abuse Control (UNFDAC), succeeding Dr Bror Rexed of Sweden who has held the post since 1978. Dr Rexed is retiring.

The commission is composed of representatives from 30 members states. New this year are Bahamas, Bulgaria, Malaysia, Nigeria, Republic of Korea, Senegal, and Zaire. Other members are Argentina, Australia, Belgium, Colombia, France, Federal Republic of Germany, Hungary, India, Italy, Japan, Madagascar, Malawi, Mexico, Norway, Pakistan, Panama, Spain, Thailand, Turkey, Union of Soviet Socialist Republics, United Kingdom, United States, and Yugoslavia.

Observers from approximately 40 other states, and representatives of UN bodies and other international organizations participated in the commission meeting.

NZ, Australia to hold joint drug hearings

AUCKLAND, NZ — In an apparently unprecedented piece of international co-operation, an Australian royal commission on drug trafficking has been given full rights to hold hearings in New Zealand and compel the appearance of witnesses living here.

The commission is principally inquiring into the Australian activities of drug syndicate boss Alexander James Sinclair (alias Terrence John Clark), now serving a life sentence in Britain for the murder of fellow drug racketeer Christopher Martin Johnstone in Lancashire in 1979.

Sinclair's Sydney-based syndicate operated in Australia, New Zealand, Asia, and Britain — and had plans to import heroin to the west coast of the United States.

Both Sinclair and Johnstone were New Zealanders, and the Australian royal commission believes there may be people in New Zealand with knowledge of Sinclair's activities and how he disposed of drug-deal profits.

The New Zealand government has agreed to accredit the commission as a commission of inquiry under New Zealand law. This will enable it to question people it believes have knowledge of the drugs scene but who could not be compelled to attend hearings in Australia.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1 sold in ¼ increase

Circulation: 15,094

(Ontario, 11,580, other provinces, 815, USA, 1,979, foreign, 720) Bulk, 3,700, Media, 1,273

Single Subscription Rates
Ontario Residents free
Other Canadian Residents $12 per year
U.S.A. & Foreign Residents $16 per year

Bulk Subscription Rates
Purchase of 5 or more subscriptions mailed to the same address — 20% discount. Ontario residents billed as other Canadians.

Member of ccab

ISSN 0044-6203 Printed in Canada

Stats Facts

(Some facts about drugs and alcohol*)

Drugs

How many use drugs?

- 50% of Canadian adults aged 15 years and older did **not** take any drugs during a two-day period (1978-79).

How many use cannabis?

- 9.7% of Durham region (Ontario) adults aged 18 years and older used cannabis in the previous 12 months (1978); 31.7% of Ontario high school students used cannabis during the last 12 months (1979).

How many use tranquillizers?

- In a 12-month period, 6.9% of Ontario students used prescription tranquillizers, and 5.9% used non-prescription tranquillizers (1979).
- During a two-day period, 5.9% of Canadian adults used tranquillizers and sleeping pills (1978-79).

How many use barbiturates/sedatives?

- In a 12-month period, 12.8% of Ontario students used prescription barbiturates, and 6.8% used non-prescription barbiturates (1979).
- During a two-day period, 5.9% of Canadian adults used tranquillizers and sleeping pills (1978-79).

How many use stimulants (amphetamine, speed)?

- In a 12-month period, 5.9% of Ontario students used prescription stimulants, and 10.6% used non-prescription stimulants; 3.6% used speed (1979).

How many use hallucinogens?

- During a 12-month period, 0.5% of Durham adults used hallucinogens (1978); 8.6% of Ontario students used LSD, and 5.3% used other hallucinogens (1979).
- There were 614 new hallucinogenic drug cases officially recorded in Canada (1979).

How many use narcotics?

- There were 19,743 Canadian habitual narcotic drug users officially recorded; of these, 5,724 were in Ontario (1979).
- During a 12-month period, 0.5% of Durham adults used cocaine, and 0.6% used other opiates illicitly (1978); 5.1% of Ontario students used cocaine, and 2.3% used heroin (1979).

How many are treated for drug problems?

- There were 2,028 cases of drug dependence treated in Canadian hospitals on an inpatient basis; of these, 752 were in Ontario (1977).

How many die of drug problems?

- 13 Canadian deaths were due to drug dependence; 392 Canadian deaths were due to adverse, or toxic effects of psychoactive medicinal agents (1978).

How many are convicted for drug offences?

- There were 35,045 convictions for drug offences in Canada; of these, 14,868 were in Ontario (1978).
- In Ontario, there were 584 drug-related juvenile delinquencies.

How many are imprisoned for drug offences?

- There were 507 admissions to Canadian penitentiaries for offences under the Narcotic Control Act and the Food and Drugs Act.

Alcohol

How many use alcohol?

- 80.4% of Canadian adults aged 15 years and older had taken at least one drink in the previous 12 months (1978-79).
- 76.9% of Ontario high school students had used alcohol at least once in the previous 12 months (1979).

How much alcohol is consumed?

- 202.2 million litres of absolute alcohol were consumed in Canada, of which 74.5 million litres was consumed in Ontario (1978-79).

How much alcohol does each person consume?

- In one year, the average Canadian aged 15 years and older consumed 11.27 litres of absolute alcohol; this is the equivalent of 12.7 drinks per week (1978-79).
- In Ontario, yearly adult consumption was 11.5 litres; this is equivalent to 13 drinks weekly (1978-79).

Where do people consume the most alcohol?

- The highest absolute alcohol consumption in Ontario was in Kenora at 18.28 litres per adult (1979); in Canada, it was in the Yukon where adult consumption reached 20.73 litres (1978-79).
- On a world-wide basis, France had the highest alcohol consumption at 16.0 litres per person (1977).

How much is spent on alcohol?

- Canadians spent $4.4 billion; of this, $1.5 billion was spent in Ontario (1978-79). In addition, $2.3 billion was spent on alcohol consumed in restaurants, at catered affairs, in taverns, hotels, motels, and tourist courts and cabins; of this, $649 million was spent in Ontario (1978).

How much revenue does the government derive from alcohol?

- The federal government derived $690 million from the control and taxation of alcohol; this accounted for 1.8% of total federal revenue.
- The provincial and territorial governments derived $1.3 billion from the control and sale of alcoholic beverages or 2.9% of all provincial revenues; of this amount, Ontario obtained $427 million, or 3.4% of its revenue (1977-78).

How many alcoholics are there?

- There were an estimated 622,750 alcoholics in Canada, of which 235,000 were in Ontario (1977).

How many drinking drivers are there?

- There were 47,728 Canadian drivers involved in accidents with ability impaired by drink, or who had been drinking; of these, 29,298 were in Ontario (1976).

How much alcohol crime is there?

- There were 376,364 offences against Canadian Liquor Acts (1979).
- In Ontario, there were 1,378 alcohol-related juvenile delinquencies (1979).

How many alcohol traffic offences are there?

- There were 148,197 driving-while-impaired offences, and 16,145 traffic offences due to failure, or refusal, to provide a breath sample. Together, these alcohol traffic offences accounted for 56.1% of all traffic offences in Canada under the Criminal Code (1979).

How many are treated for alcohol problems?

- There were 47,346 cases with the primary diagnoses of alcoholism, alcoholic psychosis, and liver cirrhosis treated in Canadian hospitals on an inpatient basis; of these, 17,269 were in Ontario (1977).

How many die of alcohol problems?

- There were 3,517 deaths with a primary cause of alcoholism, alcoholic psychosis, and liver cirrhosis in Canada; 1,263 of these deaths occurred in Ontario (1978).
- There were an additional 135 Canadian deaths due to adverse or toxic effects of alcohol, and 226 deaths due to the effect of alcohol combined with specified medicinal agents (1978).

Tobacco, Caffeine

How many use tobacco?

- 34.2% of Canadian adults aged 15 years and older usually smoked cigarettes everyday; another 3.5% smoked cigarettes occasionally (1979); 34.7% of Ontario high school students used tobacco at least once in a 12-month period (1979).

How many cigarettes are smoked?

- 60.1 billion cigarettes were smoked in Canada; this represents 9.4 cigarettes daily per adult aged 15 years and older (1977-78).

How much revenue does the government derive from tobacco?

- The federal government derived $706 million from the sale of tobacco; this accounted for 1.8% of total federal revenue.
- The provincial and territorial governments derived $491.2 million from the sale of tobacco, or 1.1% of all their revenues; of this amount, Ontario obtained $206 million or 1.6% of its revenue (1977-78).

How many consume caffeine?

- At home, 94% of Canadian household members consumed coffee, and 91% consumed tea daily; away from home, 90% consumed coffee, and 81% consumed tea. On a daily basis, these households consumed 4.93 cups of coffee at home, and 2.77 cups away from home; and 5.13 cups of tea at home, and 2.17 cups away from home (1975).

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* **By Manuella Adrian.** (Most recent statistics available selected from the *Statistical Supplement to the Annual Report of the Addiction Research Foundation of Ontario* (1979-80), 33 Russell Street, Toronto, Canada M5S 2S1.

Editor... Letters to the Editor... Letters to the Editor...

Violence a common theme in inhalant files

(from page 8)
creased flow of the hormones epinephrine and norepinephrine, resulting in heart fibrillation and instant death. Apparently, this flow was increased due to stress of fright and running, or other physical exertion. Chemicals most frequently implicated were the fluorocarbons.

Since then, there have been many observations on sniffing deaths without apparent stressful events — simply cases where victims dropped unconscious due to heart fibrillations. I am familiar with a case where snow imprints did not indicate physical activity. Subsequent scientific reports, including many laboratory reports, discount the association with physical exertion. However, sudden sniffing death is still accepted theory.

More recent observations indicate the most common cause of death is probably from suffocation due to aspiration of gastric contents which seems to occur when sniffers pass out from intense inhalation. By sniffing from saturated cloths, sniffers can control the level of intoxication for any period of time. Huffing from bags (usually oven bags or bread wrappers) increases the possibility of excessive inhalation leading to unconsciousness, but not the likelihood of suffocation from the bags.

In the United States, use of fluorocarbons as propellants was discontinued in 1979 because of, as you state, the possibility of damage to the stratospheric ozone layer. Since then several deaths have been reported, mostly due to aspiration or violence. Most aerosols now use propane-isobutane propellants.

You accurately state the absorption and accumulation potential of certain chemicals in body tissues. I have detected toluene on a sniffer's breath two weeks after the last sniffing episode.

Violence and death are certainly associated with sniffing as sniffers are more impulsive and experience neurotic fears more often. A group of skid row alcoholics in Tulsa was recently complaining to a police officer that paint sniffers were beginning to congregate in their proximity. They fear sniffers because they are more prone to violence.

Obviously, you formed your opinion that permanent brain damage is rare from the scientific literature. This might be surmised from those that indicate their own evidence, even though conclusive in their limited scope, is inadequate to assume that permanent brain damage is a common occurrence. However, after summarizing existing studies and applying opinions formulated through personal observations, contacts, experiences, and reports from other front-line mental health workers, we can conclude that organic brain syndromes and permanent psychosis are occurring among chronic inhalant users.

My files contain several citations on behavior of chronic inhalant addicts indicating various extents of chronic psychosis. Among my contacts, I frequently hear about chronically bizarre behavior which seriously impedes efforts at therapy. Some of these psychotic cases are confirmed by appropriate authorities and many involve violence and homicide or the recognized potential for violence.

During the past two years, I have conducted training seminars at 15 locations in eight states on health aspects of inhalant abuse, and these are common reports. Although not scientific in nature, these reports do correspond to the scientific literature. We need to discuss this drug abuse problem, and I hope **The Journal** will address it more.

Morris Dyer
Health Educator
Department of Health & Human Services
PHS Indian Health Center
Miami, Oklahoma

TJ 'concise'

We use much of the material in **The Journal** in our individual counseling sessions. We appreciate the manner in which it is written. Most concise.

Keep it up.

C.C. Bingham
Co-Director
CAR Institute
Renton, WA

Int'l focus valuable

You are doing an excellent job of keeping your readers informed about the ever-changing field of alcohol and drug dependence. The Journal is for me the most valuable publication in the field. I especially appreciate articles about what is happening internationally.

Dr. E. Tune
Garden Grove, CA

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Susan Reid, the coordinator of the group, at (416) 595-6150.

Let's Call It Quits

Number: 497.
Subject Heading: Smoking; lifestyle.
Details: 28 min; 16 mm; color.
Synopsis: This light-hearted film starring Tom Bosley and Marion Ross (from the TV series *Happy Days*) dramatizes the difficulties in trying to stop smoking — the routines associated with the smoking habit, and the reasons people give for smoking. A small gathering of friends at a party talk about their smoking habits and all decide to quit. Mr Bosley, however, continues to smoke furtively; he finally goes to a doctor who gives him some literature about effective ways to stop smoking. Mr Bosley makes a list of the reasons for, and against, smoking, and decides to set a deadline for the day he will be a non-smoker. He lives up to his plan, and takes up exercise, eats carrots, and quits smoking.
General Evaluation: Very-good (5.0). This well-produced, informative, and interesting film was judged to be realistic and possessing emotional impact. The group said the film was likely to produce attitudes opposed to smoking. The group disagreed with the assertion that "certain types of persons cannot quit smoking without outside help." Despite this reservation, the film was recommended for broadcast, and as a useful teaching aid.
Recommended Use: The film is intended for adults and smokers, but is likely to benefit all audiences aged 15 and older.

Drinking, Driving and Drugs: A Research Report

Number: 485.
Subject Heading: Impaired driving.
Details: 25 min; 16mm; color.
Synopsis: This documentary shows experiments designed to measure the effects of alcohol and marijuana on a person's driving abilities. Marijuana affects a driver's tracking and divided attention abilities. Although it did not affect the driver's ability to understand what is seen (visual search), some volunteers do look at items and not see them. With marijuana, the autokinetic phenomenon results in a stationary light in the dark appearing to move; higher doses of marijuana increase this apparent movement, potentially creating problems for night driving. The film ends with a question about the combined effect of alcohol and marijuana on driving, indicating that research in this area is still incomplete.
General Evaluation: Fair (3.3). The group said the film was unrealistic, and questioned the relevance of the test in measuring driving abilities. Poor editing, repetition of road footage and interview sequences, combined with an inappropriate use of graphic illustrations led the group to judge the film to be poorly-produced and boring. Despite these factors, the film may produce attitudes opposed to drinking and driving, or driving under the influence of marijuana.
Recommended Use: This film is likely to benefit its intended audience of people aged 15 and older, including drug users. A resource person would be useful in facilitating discussion.

What About Pot?

Number: 482.
Subject Heading: Drugs and youth; trigger films.
Details: 20 min; 16mm; color.
Synopsis: This documentary narrated by Greg Shannon, explores the pros and cons of marijuana use, suggesting that there is a lack of knowledge and very little agreement on this subject. One expert claims there is no physical withdrawal from marijuana, but stresses that with more than casual use (two to 10 times a month) there is a chance of psychological addiction. Using an illustration of a driving test done under the influence of marijuana, the film points out that under its influence a person's visual ability is impaired, and therefore "marijuana use will increase the likelihood of getting in an accident." The film concludes with interviews of people who have given up marijuana use and their reasons for doing so.
General Evaluation: Poor-fair (2.7). The group said that the message presented was unclear, and may, in fact, be counterproductive in terms of influencing attitudes regarding drug abuse. It was strongly recommended that this film not be broadcast. The film was considered boring, and although judged to be informative, its lack of balance implied that marijuana use is normative.
Recommended Use: The film could be used by adult audiences who might be concerned about teenagers' use of marijuana. The Group felt that with a skilled resource person, the film could be a good topic for discussion.

DEPARTMENT

New Books by RON HALL

Careers of Opioid Users

. . . by James F. Maddux and David P. Desmond

This volume describes the varied careers of 248 opioid users and the interacting psychosocial events that preceded and accompanied their opioid use. Detail is provided about the methods of the study, and considerable statistical description adds to the basis of findings and conclusions. Common patterns and variations in life experiences, and the conditions that seemed to prompt, to sustain, and to interrupt the drug-using career are identified. An attempt is made to connect observations to those of other investigators and to current theoretical concepts of opioid drug use. Chapters include: opioid use in San Antonio; family background and childhood experience; initial drug use; 20 years of opioid use; social adjustment; treatment and correctional experience; and mortality and morbidity. The final chapter presents interpretation and implications.

(Praeger Publishers, 521 Fifth Avenue, New York, NY 10175, 1981. 238p. ISBN 0-03-059817-6)

Drinking to Your Health

. . . by John A. Ewing

This book provides information on how the body handles alcohol; how much drinking is safe; how social, psychological, and inborn factors influence drinking; and how to spot the warning signs of dangerous drinking. Individual chapters address specific drinking issues for children and teenagers, men and women, alcoholics, minorities, and special risk groups. How to get help for drinking problems is described in detail including; Alcoholics Anonymous and Al-Anon, local and national sources of help and advice to people who care for someone who drinks too much. Questionnaires to detect drinking problems, and space for keeping a drinking diary are also included.

(Reston Publishing Company, 11480 Sunset Hills Road, Reston, VA 22090, 1981. 225p. $8.50. ISBN 0-8359-1473-9)

Psychotropic Drug Handbook

. . . by Paul J. Perry, Bruce Alexander, and Barry I. Liskow

This is the third edition of a guide to psychotropic drug therapy. It is a concise compilation of practical and clinical information intended for use by individuals involved in the treatment of psychiatric patients. The topics discussed are grouped under the headings antipsychotics, antidepressants, lithium, antianxiety agents, hypnotics, analgesics, agents for treating extrapyramidal side effects, disulfiram, drug interactions, management and treatment of drug overdosage, management of withdrawal, amytal interview, electro-convulsive therapy, and patient instructions. Of special interest is the inclusion of rational prescribing principles and product lists with cost comparisons for all drugs discussed in the handbook. Additional practical information for the clinician is provided in the drug interaction tables and the patient instruction section.

(Harvey Whitney Books, 4906 Cooper Road, Cincinnati, OH 45242, 1981. 198p. $9.50. ISBN 0-9606488-1-X)

Counseling Skills for Alcoholism Treatment Services: A Literature Review and Experience Survey

. . . by Donna Bain, Lisa Taylor, Peter E. Bohm, Richard Boudreau, Douglas Chaudron, and Narendra Sharma

This study is a response to the absence of organized knowledge concerning counselling skills of particular relevance to the treatment of alcohol abusers, and the means by which to evaluate them. An attempt is made to address the issues related to the identification, definition, and measurement of requisite skills for alcoholism counsellors. An investigation was undertaken to explore the following questions: 1) which treatment approaches are frequently used with alcoholics, and what counselling skills facilitate their effectiveness; 2) what are the unique needs of special client populations, and which counselling skills are particularly important in meeting these needs; and, 3) to what extent do alcoholism counsellors require unique skills? This study is an attempt to explore these questions and varied perspectives. It relies on three principal sources: research-based conclusions from the literature, theoretical stances purported in the literature, and the clinical wisdom of selected individuals experienced in the training and evaluation of counselling skills in the treatment of alcoholism.

(Marketing Services, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario M5S 2S1, 1981. 206p. $6.95.)

Other Books

The Health Consequences Of Smoking For Women: A Report Of The Surgeon General — United States Surgeon General's Office, Dept of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office on Smoking and Health, Rockville, MD, 1980.

Dimensions of Family Therapy — Andolfi, Maurizio, and Zwerling, Israel (eds), Guilford Press, New York, 1980. Family therapy and community psychiatry; society and the family; drug abuse and the family; couple therapy; schizophrenia; training. 280p. $20.

Peyote: The Divine Cactus — Anderson, Edward F., University of Arizona Press, Tucson, 1980. Peyote in Mexico, United States; ceremonies; user's experience; medical use; pharmacology; chemistry, botany; legal aspects. Appendices, bibliography, index. 248p. $18.50.

Ethnic Drinking Subculture — Greeley, Andrew M., McCready, William C., and Theisen, Gary, Praeger, New York, 1980. Ethnicity and alcohol; approaches to ethnicity, drinking subcultures; socialization subcultures; drug usage and drinking among ethnic groups; drinking subcultures and assimilation. Appendices, bibliography, index. 138p. $15.95.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Alcoholism and Your Patient — May 13, Toronto, Ontario. Information: Linda Bell, The Donwood Institute, 175 Brentcliffe Road, Toronto, ON M4G 3Z1.

Cognitive Behavior Therapy — May 14, Toronto, Ontario. Information: E. Essue, Clarke Institute of Psychiatry, 250 College Street, Toronto, ON M5T 1R8.

Mental Health Information Systems: Problems and Prospects — May 14-15, Toronto, Ontario. Information: Hincks Lectures, Ontario Mental Health Foundation, Suite 1708, 365 Bloor Street E, Toronto, ON M4W 3L4.

1982 Western Canadian Alcholism Conference — May 26-28, Regina, Saskatchewan. Information: Conference Chairman, 2839 Victoria Avenue, Regina, SK S4T 1K6.

Summer School on Addictions — June 20-25, Charlottetown, Prince Edward Island. Information: The Dept of Extensions and Summer Sessions, University of Prince Edward Island, Charlottetown, PEI C1A 4P3.

73rd Annual Conference Canadian Public Health Association — June 21-24, Yellowknife, Northwest Territories. Information: Gerald H. Dafoe, Executive Director, Canadian Public Health Association, 1335 Carling Avenue, Suite 210, Ottawa, Ontario K1Z 8N8.

Summer Course in Addictions — July 19-23, Toronto, Ontario. Information: School for Addiction Studies, 8 May Street, Toronto, ON M4W 2Y1.

Workshop on Evaluation Research in the Addictions Field — Sept 7-9, Regina, Saskatchewan. Information: Brigitte Neumann, Nova Scotia Commission on Drug Dependency, 5668 South Street, Halifax, NS B3J 1A6.

United States

Assessment and Diagnosis For Chemical Dependency — Apr 16, June 8, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Training School on Alcohol and Drug Abuse — Apr 19-May 7, Minneapolis, Minnesota. Information: Mary Simonson, Johnson Institute, 10700 Olson Memorial Highway, Minneapolis, MN 55441-6199.

First National Symposium on Psychoimmunology - The Impact of Brain, Behavior and Emotion on Immunity to Disease — Apr 24-25, New York, NY. Information: Institute for Psychosocial Study, 221 E 50 Street, NY, NY 10022.

Midwest Conference on Alcohol and Drug Abuse — Apr 25-29, Midland, Michigan. Information: James R. Tarrant, Director of Medical Education, 615 Ninth Street, Bay City, MI 48706.

Workshop on Chemical Dependency and Adolescents — Apr 25-30, Minneapolis, Minnesota. Information: Betty Reynolds, Johnson Institute, 10700 Olson Memorial Highway, Minneapolis, MN 55441-6199.

Recover or Repeat — Apr 27, Lansing, Michigan. Information: Michigan Alcohol and Addiction Association, 29563 Northwestern Hwy, Suite #7 - Bldg F, Southfield, MI 48034.

Two Rival Psychotherapies Move Toward Convergence — May 1, New York, NY. Information: Institute for Psychosocial Study, 221 E 50 Street, New York, NY 10022.

8th Annual School on Addictions Studies — May 3-6, Anchorage, Alaska. Information: Janice Oglietti, Coordinator, Center for Alcohol and Addiction Studies, University of Alaska, Anchorage, AK 99508.

7th World Conference of Therapeutic Communities — May 8-13, Chicago, Illinois. Information: Donna Gleixner, Gateway Houses Foundation, Inc, 624 S Michigan Avenue, Chicago, IL 60605.

Pastoral Training for Chaplains in Rehabilitation Settings — May 10-12, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

An Integrated Management System for Administrators in Alcoholism — May 13-14, Boise, Idaho. Information: Kim Hilberg, Program Coordinator, NAATP, 17861 Cartwright Road, Irvine, California 92714.

Cocaine Today — May 13-14, Santa Monica, California. Information: Lee Dogoloff, ACM, 6193 Executive Boulevard, Rockville, Maryland 20852.

Drug Abuse Prevention for Parents and Professionals — May 16-19, Charlotte, North Carolina. Information: Charlotte Drug Education Center, 1416 E Morehead Street, Charlotte, NC 28204.

Nursing Series - Pharmacology, Detoxification and Withdrawal: Basic Skills, Counseling Skills for the Nurse — May 17-21, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Toxicology of the Immune System — May 20-21, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Third Annual Illinois Institute on Drug Abuse — May 24-27, Peoria, Illinois. Information: IDDC, 300 N State Street, Chicago, IL 60610.

Alcohol/Drug Counseling Skills II — May 24-28, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

National Conference on Alcoholism and the Family — May 27-30, Valley Forge, Pennsylvania. Information: National Conference on Alcoholism and The Family, Box 277, Wernersville, PA 19565.

Fundamentals of Biochemistry and Genetic Engineering — June 2-4, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Issues of Sexuality in Alcoholism/Drug Abuse Counseling — June 3-4, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

University of Utah School on Alcoholism and Other Drug Dependencies — June 20-25, Salt Lake City, Utah. Information: University of Utah School On Alcoholism and Other Drug Dependencies — PO Box 2604, Salt Lake City, UT 84110.

The Mid-South Summer School on Alcohol and Drug Problems - Prevention and Treatment — June 20-25, Fayetteville, Arkansas. Information: Gwen Briscoe, GSSW-UALR, Little Rock, AR 72204.

Alcohol Studies Program — June 21-Aug 13, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, 12th and E Columbia, Seattle, WA 98122.

33rd Annual Symposium on Alcoholism — June 21-July 2, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, 12th and E Columbia, Seattle, WA 98122.

Sexuality for Alcoholism Counselors — June 22-July 13, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, 12th and E Columbia, Seattle, WA 98122.

6th Annual Summer Institute of Drug Dependence — Aug 29-Sept 3, Colorado Springs, Colorado. Information: The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Evaluating Alcohol and Drug Problems: Current Methods and Findings — Sept 13-17, Brooklyn Park, Minnesota. Information: Leslie Nyberg, Evaluation and Research Development, Box 11, Center City, MN 55012.

The Benzodiazepines Today: Two Decades of Research and Clinical Experience — Oct 9-10, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton Street, San Francisco, CA 94117.

Women In Crisis, Inc, Fourth Annual Conference — Nov 10-13, New York, NY. Information: Women In Crisis, Inc, 37 Union Square West, New York, NY 10001.

Family Program For Professionals — Offered once each month, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Scholarly Communication Around The World - The 27th Annual Conference of the Council of Biology Editors, The 3rd International Conference of Scientific Editors and The 5th Annual Meeting of the Society for Scholarly Publishing — May 15-20, 1983, Philadelphia, Pennsylvania. Information: 1983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Service, 2100 Arch Street, Philadelphia, PA 19103.

Abroad

10th International Conference of Social Gerontology — May 26-28, Deauville, France. Information: ICSG, 91, rue Jouffroy, 75017 Paris, France.

First Nordic Congress on Traffic Medicine — June 8-11, Linköping, Sweden. Information: Leif Bohlin, Congress Director, Linköping University, S-581 83 Linköping, Sweden.

13th Collegium Internationale Neuro - Psychopharmacologicum Congress — June 20-25, Jerusalem, Israel. Information: Secretariat, 13th CINP Congress, POB 29784, Tel Aviv, Israel.

28th International Institute on the Prevention and Treatment of Alcoholism — July 5-9, Munich, Fed Rep of Germany. Information: International Council on Alcohol and Addictions, Case postale 140, 1001, Lausanne, Switzerland.

Second Biennial AU School of Justice Institute on Juvenile Justice — July 11-30, London, England. Information: Dean Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

Fourth World Congress for the Prevention of Alcohol Problems, Alcoholism and Drug Dependency — Aug 29-Sept 2, Nairobi, Kenya. Information: ICPA (International Commission for the Prevention of Alcoholism and Drug Dependency), 6830 Laurel St NW, Washington, DC 20012.

33rd International Congress on Alcoholism and Drug Dependence — Oct 9-15, Tangier, Morocco. Information: Archer Tongue, International Council on Alcohol and Additions, Case postale 140, 1001 Lausanne, Switzerland.

Influence of Environment on Man — Nov 17-20, Vienna, Austria. Information: Secretariat Brussels, rue E Bouillot 61 Box 11, B-1060 Brussels, Belgium.

VII World Congress of Psychiatry — July 11-16, 1983, Vienna, Austria. Information: Congress Team International, PO Box 9, A1095 Vienna, Austria.

Alcohol, society, the state — a global view

Governments strive for balance as controls slip away

Single: '. . . health concerns about alcohol use should be on the same agenda for policy-makers as revenue concerns . . .'

By Wendy Wright

TORONTO — Alcohol control policies are political footballs kicked around by governments and politicians trying to balance both the economic and health needs of the nation.

Whether in the East or the West, governments are trapped in a conflict of interests which are economic, political, and social, a report to the World Health Organization (WHO) by the International Study of Alcohol Control Experience (ISACE), has shown.

The report — *Alcohol, Society, and the State* — took four years to complete and contains studies made in Poland, Finland, Switzerland, The Netherlands, Ireland, the province of Ontario, and the state of California, of historic and cultural factors affecting controls, formally and informally.

A separate volume presents guidelines for alcohol control methods to be considered by policy makers, and demonstrates how control policies influence consumption.

The cultural-historical approach of the study drives home a number of basic observations by the authors. Patterns of drinking and the social reactions to drinking vary from one context to another. Different cultures perceive alcohol-related problems differently. What works in one situation does not necessarily work in another.

While the study shows how cultures differ, it also reveals common trends. There is a general increase in consumption and availability; controls are being liberalized in keeping with the erosion of the special status once accorded alcohol. As the state controls more aspects of the economy, it finds itself more responsible for balancing the profits of the alcohol business and the concerns of public health.

Eric Single, research scientist at the Addiction Research Foundation of Ontario who took part in the study, told **The Journal** the report is exceptional in at least two respects.

First, each study has been done by resident researchers whose observations and measurements are based on criteria specific to each culture. Second, the study includes Communist Poland, which was surveyed before the military government takeover.

What makes the Polish situation particularly interesting is the fact that Poland has a planned economy, but trends in alcohol consumption and problems are remarkably similar to those in the West.

Benign attitude

Alcohol consumption had risen in Poland, as it had in Western Europe, since the end of World War II. But the government had maintained a benign attitude to control. The reason was that the government used alcohol to control inflation by absorbing consumer-buying power.

Thus the economics of alcohol overrode the health problems associated with drinking in Poland's list of priorities.

(Before Solidarity was crushed, the leaders of the union, who did not want a repetition of the violence associated with strikes in 1970, called for local prohibition during strikes. Solidarity members working in liquor stores were asked to close the stores for the day whenever there was a strike.)

When Finland attempted to exercise controls, these too, backfired. Dr Single said Finns "frequently will not drink except to get drunk. The idea of having two or three beers, and stopping there, is considered by many Finns a waste of alcohol."

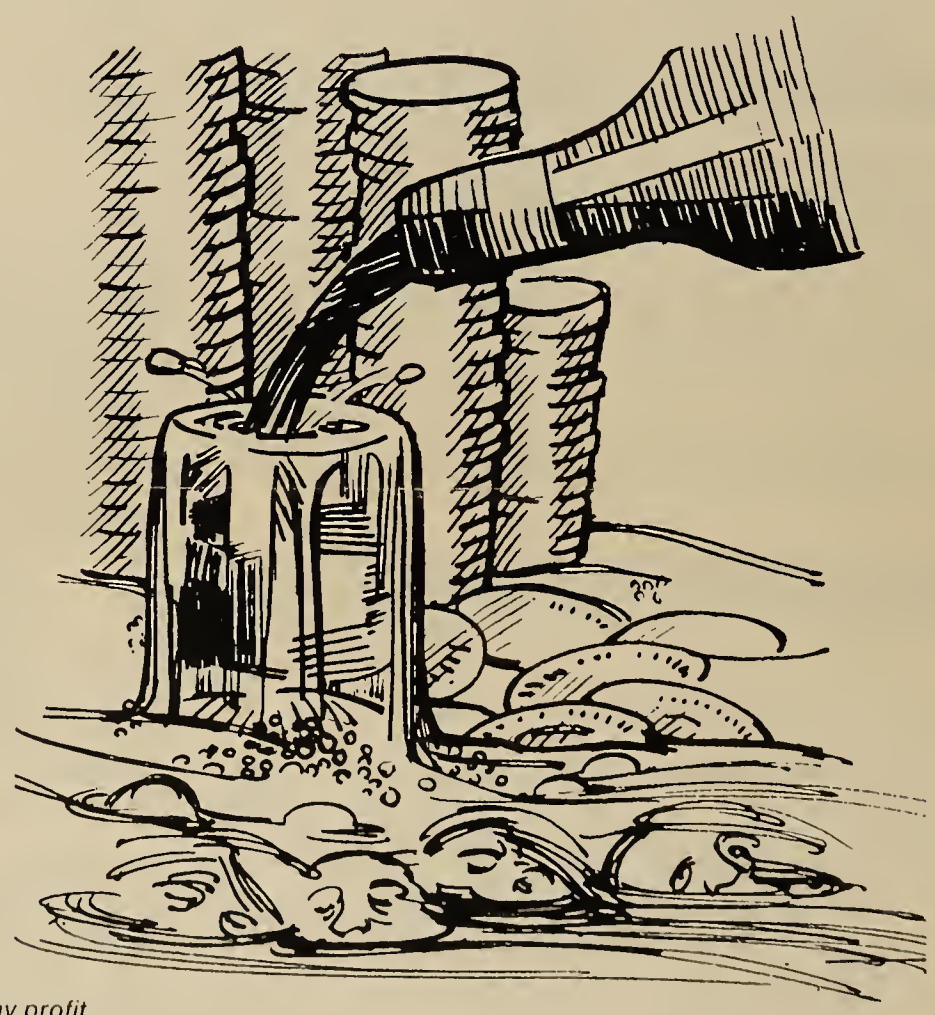
In 1969, the Finnish government decided people should learn "sophisticated, modern drinking styles." The government reasoned that if the Finns were to drink in a manner similar to the French and Italians — in terms of what, when, and where — alcohol-related problems would diminish.

Controls were liberalized and beer and wine were encouraged as options to spirits. The result? Alcohol consumption doubled in one year, and alcohol-related problems increased.

Dr Single calls the experiment "a colossal failure."

The study found The Netherlands had the fewest controls on alcohol. The Dutch can readily purchase wine and beer in grocery stores, gas stations, snack bars, and from vending machines.

The amount of drinking has risen rapidly since World War II and the study links this increase, in part, to "a decline in temperance sentiments."



Unhealthy profit.

Meanwhile, in Ireland, sanctions against women kept them out of public drinking houses (pubs) until the end of World War II, and the drinking rate for the entire country was the lowest in Western Europe until the late 1960s.

But, as informal social controls began to erode — those of the family and of the church — and when migration began to shift from the countryside to the cities, those social controls lost their impact.

Now, says the study, excessive drinking and drunkenness in Ireland are major social problems.

Alcohol consumption is also up among Switzerland's three major cultural groups: German, Italian, and French. The Italian and French regions of Switzerland record a high level of wine consumption, while the German region favors distilled spirits.

The wide differences in the rates and patterns of drinking behavior among the three language groups are strong indicators of the importance of cultural factors in alcohol consumption, because all three groups have essentially the same alcohol control system.

Dr Single points to California as a "classical case of the industry controlling itself. Health interests are largely ignored. The (alcoholic beverage) industry writes its own rules."

He says alcohol beverage control laws simply serve to help the industry's own marketing. During the period of the study, alcohol consumption in California increased, but not dramatically.

In Ontario, the study finds that after World War II, drinking was limited, generally, to working-class, urban males. Alcohol was strictly controlled, and public drunkenness was a problem for the police.

As controls were liberalized in the 1970s, alcohol use became widely-accepted socially. New drinkers appeared — women, youths, and immigrants. Public drunkenness was no longer a legal, police problem, but one for medical professionals to handle.

The study winds up with five major conclusions about the role of the state in alcohol control.

The first points to a conflict between governments' interests in both health and economics. Dr Single: "The health concerns and the problems associated with alcohol use ought to be on the same agenda in policy-making as the revenue concerns and the economic benefits of alcohol. Concretely, that means the Liquor Control Board of Ontario ought to be concerned with health problems. And we, as health professionals — when we make policy recommendations — ought to be concerned with what impact that would have on the jobs of people in the alcohol industry, and ways in which we might ameliorate a negative impact."

Political gains

In the West, consideration of short-term political gains seems to dictate who the winner is when health policies are balanced against economic policies. It is for this reason that the study suggests combining the two functions under one administration.

The second conclusion deals with the tensions created by the welfare states' growing involvement in both managing the economy and handling health problems — including alcohol.

An increasing number of governments are finding the welfare state expensive to maintain. Fiscal concerns result in tightening of budgets for treatment facilities.

One way governments handle alcohol problems is by redefining them. Since social drinking has a high degree of acceptance, there is a tendency to zero-in on the deviant drinker.

Dr Single says this fails to deal effectively with the real problem drinker — the middle-class, working male. Instead, concern is focused on politically weak groups — teenage drinkers, elderly drinkers. This is the cheaper approach.

"It's a way of deflecting public attention from more expensive ways of managing problems," says Dr Single. In the United States, he says, attention has been focused on teenage drinking when there has been no indication it has increased.

"Any singling out of deviant drinkers — even for treatment — carries with it the labelling of this individual as 'an alcoholic.' It's much more preferable to prevent the problem in the first place."

The third conclusion is that governments must be careful when considering changes in alcohol policies. Complex cultural, social, and political phenomena are linked tightly to alcohol issues. "Sudden and drastic interventions by the state in drinking practices have often had untoward, and unintended effects," the study says.

Social acceptance

Most governments have relaxed alcohol controls because of greater social acceptance of its use. By the same token, the study suggests governments might avoid further relaxation of controls as a way of reflecting and reinforcing "the more restrictive, popular sentiments about drinking that are visible in many countries today."

While the ISACE group is committed to preventive alcohol control measures, the fourth conclusion is an attempt to make the environment safer for drinkers.

This is not meant to undermine the preventive approach. It accepts the role alcohol plays in developed, industrial societies, but it doesn't absolve governments from doing all they can to minimize alcohol-related problems.

Dr Single: ". . . (We wish to prevent) the consequences that occur from a given level of consumption . . . Just because we are arguing (for prevention) doesn't mean we are against other kinds of approaches as well."

The final conclusions focus on the Third World. There is fear alcohol manufacturers will expand markets by using Third World countries as dumping grounds for excess production, and, perhaps, divert planned use of alcohol as a fuel, to that of a beverage.

The ISACE study warns government policy makers of the dangers of giving the alcohol industry incentives to expand, without considering what will happen to that excess production.

The last conclusion warns alcohol should not be used as a bargaining tool in international trade agreements. The associated health and social problems are too high. Countries entering into trade negotiations will export alcohol because it is good for their international balance of payments, but no health or social concerns for the importing country are considered. The study suggests the WHO and other international organizations might have to oversee such trade policies and arrangements.

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Vol. 11 No. 5 2nd Class Mail Reg No. 2776 TORONTO, May 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Care is key in alcohol withdrawal

Drug therapy is unnecessary

ORLANDO, FL — Eighty-five per cent of patients with mild to moderately severe alcohol withdrawal, and 60% of hospitalized patients in severe alcohol withdrawal, can improve rapidly without any pharmacologic treatment, reports a group of researchers at the Addiction Research Foundation of Ontario (ARF).

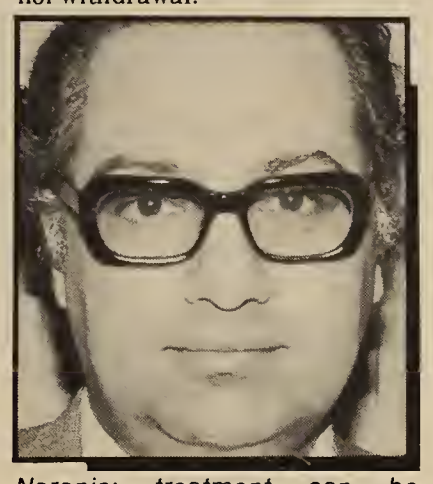
The key to minimizing drug therapy in alcoholic withdrawal is hourly, systematic nursing care, says Claudio Naranjo, head of the ARF's clinical pharmacology program.

And hospitalized patients in severe withdrawal who can't be treated with supportive care alone, respond quickly to oral diazepam (Valium) loading — a concept that gets quick results with a minimum of doses by taking advantage of the long half-life of diazepam and its active metabolite.

By giving 20 mg of diazepam every hour, Dr Naranjo and colleagues have shown that 50% of patients in severe withdrawal will be clinically asymptomatic after three hours of treatment, and the vast majority will be significantly improved after 12 hours or less.

In an interview here at the annual meeting of the American Society for Clinical Pharmacology and Therapeutics, Dr Naranjo described the shift away from long-term pharmacologic treatment of alcohol withdrawal as a way of greatly simplifying treatment, without sacrificing effectiveness.

The high success rate of the new approach contradicts the accepted belief that drug therapy is indispensible in the treatment of alcohol withdrawal.



Naranjo: treatment can be simplified.

"It's interesting because it's always been assumed that you always have to give a drug to patients in alcohol withdrawal," Dr Naranjo says. "And not only do you have to give a drug, but you have to give it frequently over a period of five to seven days."

In addition to eliminating, or drastically cutting down, drug treatment, Dr Naranjo says the new method has the added advantage of reducing the potential for drug toxicity and cross-addiction.

"The shorter the drug treatment, the better," he adds.

The conclusions are based on the results of two studies recently carried out by the Toronto investigators. In both studies, clinical progress was evaluated objectively every hour using a new scale developed at the ARF — the Clinical Institute Withdrawal Assessment for Alcohol (CIWAA).

The CIWAA categorizes alcohol withdrawal as mild, moderate, or severe. The 15 most-common symptoms of alcohol withdrawal are each assigned a score of between zero and seven, depending on the severity of a particular symptom. Scores for the individual items are added up, giving a score that reflects overall severity of symptoms. By applying the CIWAA every hour, nurses taking care of patients in alcohol withdrawal may easily follow clinical progress and the effectiveness of therapy over time.

Dr Naranjo says the CIWAA has a high rate of correlation between different raters and, as a result, is a reliable, objective yardstick by which to measure clinical improvement.

The first study was carried out in the ARF's emergency depart-

(See — Drug — page 2)

Irreversible brain damage revealed in people sniffing toluene

By Wendy Wright

TORONTO — A strong association between chronic sniffing of the solvent toluene and irreversible brain damage has been shown by Addiction Research Foundation (ARF) scientists in the largest, most comprehensive study of its kind.

The findings are important, not only for young abusers, but also for industrial workers chronically exposed to substances containing toulene, the research team says.

The ARF study links long-term use of toluene, which most abusers choose to sniff, to short-term memory loss, and fine-motor defecit.

The cerebellum appears to be the part of the brain most sensitive to toluene. Brain scans show the cerebellum being "eaten away."

Toluene is cheap and easy to obtain. In highly-concentrated form, it's found in contact cement and contact cement cleaner. Gasoline and paint thinners contain toluene in lesser concentrations.

Luis Fornazzari, neurologist with ARF, and a member of the team that did the study, says the number of people deliberately abusing toluene is low.

However, the effects are critical, considering abusers are generally quite young, and their bodies still developing. The fact that neurological damage is irreversible for chronic users makes the effect alarming.

Consistent with the cerebellum damage, the researchers found the subjects in the study had trouble with coordination — especially fine motor coordination. Some had great difficulty eating and writing.

The ventricles and sulci (grooves) on top of the brain were observed to be enlarged, indicating further atrophy around these spaces. The marked loss of short-term memory seen in the subjects is related to destruction in this area of the brain, suggests the study team.

Until now, research on the effects of solvents concentrated on the acute effects because the number of abusers who sniff for long periods of time are relatively low compared to those who try it occasionally.

(The study team presented their findings to a seminar on solvents sponsored by the ARF's School for Addiction Studies. Dr Fornazzari was also to present the findings at the end of April at a meeting of the American Academy of Neurology in Washington.)

Manufacturers should look for toluene substitutes, says Adrian Wilkinson, ARF scientist. p2

'Americans are outraged'

US moves on drinking drivers

By Michelle Kogstad

WASHINGTON — The long-awaited White House Commission on Drunk Driving has been set up by United States President Ronald Reagan.

The 30-member commission will be headed by Jon Volpe, former governor of Massachusetts and secretary of transportation under former president Richard Nixon.

The commission has been directed to increase public awareness of the drunk-driving problem, help the states deal with the problem in an organized, systematic manner, and encourage the use of the latest in technology in curbing drunk driving and generating local support for harsher law enforcement.

In a ceremony on April 14, President Reagan said more than half the 50,000 deaths on US roads each year are caused by drunk drivers and "Americans are outraged that such slaughter can take place on the highways."

Reagan: half of all road deaths caused by drunk drivers.

The commission is the result of a letter last fall from Congressmen Michael Barnes and John Hanson and 339 other members of Congress who sought a federal stand on the issue (**The Journal**, Feb).

President Reagan said the issue can only be attacked on the state and local levels. He tied the drunk-driving issue with more use of seat belts, a pet project of National Highway Traffic Safety Administrator Ray Peck.

At the same time, while the commission has been formed, Congressional officials said the administration opposes a federal bill encouraging states to set up comprehensive, alcohol and traffic safety programs.

The administration objects to a provision which denies funds for building highways to a state if it does not adopt a minimum drunk-driving program.

Some changes are already underway in the original bill, Bill Bronrott, spokesman for Representative Barnes, one of the authors of the legislation, told delegates to the annual conference here of the National Council on Alcoholism.

Changes include dropping the idea of mandatory jail sentences for first offenders. "After much time in the field talking, and listening, we decided that was a bad idea," he said.

It became clear that if judges were told they would have to put first offenders in jail, a lot of cases would be plea-bargained down to non-alcohol-related offences, "and we want to keep them alcohol related," Mr Bronrott added.

New director appointed for UN drug division

TORONTO — Tamar Oppenheimer, a United Nations official in New York since 1946, has been named new director of the UN Division of Narcotic Drugs (DND).

Mrs Oppenheimer, a graduate of McGill University, Montreal, succeeds Dr George Ling who was appointed to the term position in 1975.

Formerly, Mrs Oppenheimer served as chief of training and examinations in the recruitment program section of the UN, and before that as a senior human rights officer.

Mrs Oppenheimer will assume her new duties at DND headquarters in Vienna, Austria. The length of her appointment has not yet been specified. However, Max Tortel, who is now acting in Mrs Oppenheimer's former position, says the appointment will likely be effective until her retirement in a few years.

INSIDE

NEWS

Briefly...

Multiple Rx danger

TORONTO — The Ontario College of Physicians and Surgeons must come up with ways to stop addicts from collecting multiple prescriptions from doctors and pharmacies, a coroner's inquest here has recommended. The inquest examined the death of William Coyle, 30, who had obtained prescriptions for more than 900 pills during the three weeks before his death. Cause of death was an accidental overdose of propoxyphene (Darvon) in combination with alcohol.

Some facts ignored

LONDON — Twenty-five percent of GPs in a survey here were unaware of any link between cigarette smoking and heart disease, and 17% did not associate smoking with lung cancer. Although the sample was small (200 doctors), the *New Scientist* spelled out some implications: "A quarter of the doctors approached not only never read medical journals, nor attend any gatherings of their kind, but are also 'too busy' to read newspapers and magazines, or to watch telly, or to listen to the radio." The survey was conducted by Lundbeck Ltd, British distributor of the Swedish kick-the-habit gum, Nicorette.

B-beer better?

SYDNEY, AUS — How to fight malnutrition in alcoholics? Add vitamin B to beer. The only people who show vitamin B deficiencies in Australia are alcoholics. A trial at the University of Brisbane has shown the B-fortified beer tastes just as good as the plain stuff. Tasters tried both types, with different amounts of the vitamin added, and couldn't tell the difference.

Crime rising slowly

OTTAWA — Drug offences appear to be rising more slowly than other types of crime in Canada. In comparing the first nine months of 1981 with the same period in 1980, the Canadian Centre for Justice Statistics reported crimes of violence increased 4.4%, crimes against property 6.8%, and shoplifting 10.1%. But drug offences, mainly involving pot, crept up only 2.3%. And while cocaine charges climbed, heroin offences fell 8.5%. (The up-and-coming crime is credit card fraud, which rose 27%.)

Water pipe hazard

JEDDAH, SAUDI ARABIA — Warning: Water pipe smoking can be dangerous to your health. Researchers at the King Abdul Aziz Medical College report higher levels of carbon monoxide in the blood of *sheesha* (traditional water pipe) smokers than in cigarette smokers. Those enjoying the relaxing social past-time also complain more often of headaches, dizziness, blurred vision, and heart palpitations. The bubbling water, it seems, filters out most of the nicotine in the Jurak (paste made from tobacco, banana, and molasses), so water pipe smokers must drag more deeply to get a buzz, which increases the amounts of carbon monoxide and particulate matter entering the lungs.

US will boost alc research budget

Reagan rep tells NCA

WASHINGTON — Increased research in the alcohol field is a priority health matter for President Ronald Reagan's administration, says Edward Brandt, assistant secretary for health, in the United States.

Dr Brandt says consideration of the fiscal 1983 budget shows an increase for both extramural and intramural research within the public health service (which includes the National Institute on Alcohol Abuse and Alcoholism) into the problems of alcoholism and those caused by alcohol.

"During a period when most domestic programs are undergoing reductions, or a significant decrease in the rates of growth, the president is asking for a 50% increase in alcoholism research dollars, from the current year's level of $21 million, to a projected 1983 level of $33 million," he told the annual conference of the National Council on Alcoholism here.

Dr Brandt says the proposed expansion of new grant awards to 58, he hopes, will deal with such subjects as diagnostic techniques, effective approaches to treatment, new information to be drawn from genetic research, and prevention.

Dr Brandt defends the Reagan decision to introduce state block grants for alcohol, drug abuse, and mental health.

Some uneasiness has been voiced during the past year about the shift of responsibility from Washington to the states but "it was our contention then, as it is now, that such a shift was essential, if we really wanted those service programs to be responsive to state and local needs."

Industry 'objects totally'

Quebec calls for 'moderate' drink adverts

OTTAWA — A Quebec proposal to force alcohol beverage advertisers to devote half of their ads to warning messages has drawn the ire of corporate interests.

A working paper from the Provincial liquor permit authority (Régie des permis d'alcool du Québec), has, as perhaps its most controversial suggestion, suggested that 50% of any alcoholic beverage advertisement should be devoted to warning the consumer about the effects of product abuse. Alternatively, 50% of an ad should encourage moderate and intelligent use of the product advertised.

This drew a vehement reply, from Hubert Pitre of the Quebec Brewer's Association.

"(We) object to this working paper totally," says Mr Pitre, the association's general-manager. "What this document is aiming at is just not known. We are waiting until the Régie tells us what they want to achieve . . . The day they do, we will be available immediately to cooperate or collaborate on any kind of research."

Quebec's provincial association of people and groups working in the addictions field (AITQ — l'Association des intervenants en toxicomanies) has been consulted, and has urged Quebec authorities to match all beverage industry advertising expenditures with equal resources promoting health.

Other key sections (in translation) of the working paper that are related to advertising include:

"In general, an advertising message is to be conceived in a way that it does not constitute encouragement of consumption of alcoholic beverages, but instead provides an indication of the availability of a product."

The working paper continues: "No advertising message is to encourage a minor to consume alcoholic beverages; or present, directly or indirectly, the consumption of alcoholic beverages as:

- An aspect in the self-esteem of a person, a group, or a collectivity;
- An indication of social prestige or business success, or of a way of improving personal performance;
- An element necessary to a person's participation in some activities;
- Associating a sporting activity with the consumption of alcoholic beverages;
- Encouraging the consumer to consume alcoholic beverages in an immoderate way; and
- Showing people in activities where the consumption of alcohol is prohibited."

The working paper recommends "no advertisement may use a personage represented by someone whose activities are known to the public or whose activities are mentioned or referred to."

Proposed advertising would have to be submitted to the Quebec liquor permit authorities 30 days before its scheduled appearance or airing, and promotional activities would have to be cleared at least 15 days before an event.

Toluene substitutes should be sought

TORONTO — Manufacturers of substances containing toluene need to investigate substitutes for the hazardous solvent, says Adrian Wilkinson, a scientist with the Addiction Research Foundation of Ontario (ARF).

Dr Wilkinson is a neuropsychologist and member of the ARF team that has shown that chronic inhalation of toluene is associated with irreversible brain damage **(see page one).**

"You don't have to use toluene as a solvent in glue. There are a variety of solvents that could be used," Dr Wilkinson told The Journal.

He said manufacturers must do more research on any substitutes for toluene to make sure they are neither physically harmful nor addictive, and yet still ensure the compound can do the job for which it was intended.

"At least if a manufacturer wants to avoid publicity and social irresponsibility, they can use this sort of information in making some decisions about formulation of products.

"Usually, they only base it on whether it works as a good glue. I think this is another consideration that manufacturers might want to take into account."

The maker of one popular contact cement cleaner — LePages' Ltd — has, in the light of the ARF study, reformulated its product eliminating toluene.

A spokesman for LePages' reports they were "deluged" with complaints from across the country for six months after they eliminated toluene from contact cement cleaner. He suspects most complainers were abusers.

Drug intervention unnecessary in most alc withdrawal cases

(from page 1)

ment in 41 patients going through mild to moderately-severe alcohol withdrawal, determined by the CIWAA. During the first two hours after assessment, all the patients received identical, systematic, supportive nursing care. This consisted of reassurance, reality orientation, administration of fluids, and making sure the patient was as comfortable as possible. Patients were isolated in quiet, dimly-lit rooms. After the initial assessment, the CIWAA was applied every hour.

After two hours of supportive care, the patients were randomized into two groups. Twenty-one received 2 mg of lorazepam sublingually every two hours for a total of three doses, plus hourly assessment and supportive care. The rest of the patients received sublingual placebo every two hours three times, and continued to receive hourly supportive care and the CIWAA assessment.

Although the patients receiving active drug improved more rapidly during the first two hours of the study, Dr Naranjo says after this time the rate of improvement in both groups was similar over a five-day, follow-up period.

"These results show that 85% of patients with mild to moderately-severe alcohol withdrawal will improve without any pharmacologic intervention when systematic supportive care is carefully given."

The investigators then turned their attention to the effectiveness of supportive care in patients hospitalized with severe alcohol withdrawal. Fifty inpatients were randomized so that 25 received supportive care and the CIWAA assessments plus 20 mg of diazepam orally every hour until symptoms disappeared, and the other half were given supportive care, assessments, and placebo every hour until they were asymptomatic.

Summarizing the results, Dr Naranjo says: "The interesting thing was that again, a substantial proportion of the subjects who did not receive active drug improved significantly in a very short period of time. Within eight hours, 60% were treatment successes and required no further treatment."

As in the previous study, Dr Naranjo says the rate of improvement within the first two hours was faster in the diazepam group, but after this time was similar in both groups.

In the active drug group, 50% improved significantly with only three doses of diazepam and virtually all were asymptomatic with 12 doses or less.

In a small study of eight patients in severe alcohol withdrawal who did not respond to supportive care alone, 20 mg of diazepam was infused intravenously every hour until symptoms disappeared. As with oral diazepam, intravenous administration produced rapid improvement with a minimum of doses. All these patients improved between 0.8 and four hours on doses ranging from 15 mg to 94 mg. No further treatment was necessary.

DWI countermeasures: enforcement may be best

TORONTO — Law enforcement and legislation may be the best deterrent to drunk drivers, a study by researchers at the Addiction Research Foundation has suggested.

What does not seem to work well is drunk-driver education programs which were evaluated: "(they) have shown a disappointing rate of recidivism.

The study by Evelyn Vingilis, PhD, and colleagues was presented at a Study Week in Traffic Safety held at the University of Toronto here.

The report says that while countermeasures against drunk drivers have been taken in a number of countries, because of a shortage of sound scientific data "it has often not been possible to determine whether the countermeasures have been effective in reducing the incidence of drinking after driving."

What has been a great asset is development of breath-testing machines. Detection rates could go even higher if legislators allowed broader application of the machines.

The researchers said it was probable an increase in the detection rate among drunk drivers would cause members of the public to think more about their chances of being caught.

5-year plan aims for non-smoking majority

Canada wants smoke-free 1987

TORONTO — A national campaign to make non-smokers the majority will be launched in Canada this month.

Called "Towards a Generation of Non-Smoking Canadians," the program idea springs from a Swedish plan designed to bring a cohort of children from birth to adulthood as non-smokers.

Although the Canadian program echoes Sweden's, its scope will be broader, says Barbara Ouellet, tobacco programs officer, alcohol, tobacco and risk assessment unit, Health Promotion Directorate.

She told **The Journal** the five-year program will aim at promoting a social atmosphere in which non-smoking is the norm. Media messages, school, and other community programs are being developed for different groups in society.

"Anti-smoking campaigns have been effective to a certain extent in decreasing smoking among adults, particularly among men. But we continue to see young females, in particular, starting to smoke, and young kids are starting to experiment with cigarettes at younger ages," Ms Ouellet says.

Initial television messages will be aimed at 12- to 15-year-olds: "That's certainly where the problem exists. It may be even a little late for prevention, but that's the age where TV is thought to be most effective in creating a positive image for the non-smoker," she adds.

The federal government will spend $1.8 million this year on the campaign, and Ms Ouellet expects that figure to remain constant, if not increase, for the duration of the five-year plan. Additional financial and manpower support is expected to come from provincial health departments and agencies, as well as voluntary groups, whose activities Ottawa hopes will be coordinated with the federal government.

"Initially, we are approaching some of the major organizations — heart, cancer, lung — but over the five years we're hoping to evoke interests in professional groups, parents' groups — anyone that can play a role in community programs," says Ms Ouellet.

Further programs are expected to be developed for preschool children, pregnant women, and other adults, especially parents.

"Our research has told us that the majority of people who quit smoking tend to do it on their own. So we are looking specifically at new approaches in self-management that could be reinforced through TV and the community," Ms Ouellet explains.

GENERATION

Global view, flexibility winning war for drug traffickers

By Harvey McConnell

CINCINNATI — Drug traffickers are fast and smart, and can respond quickly to events, be they droughts or political upheaval.

"Drug traffickers are way ahead of the rest of us in the (drug abuse) field. They recognize, as nothing else, that it's a very, very small world," according to Anne MacLennan, editor of **The Journal**.

Ms MacLennan reviewed international drug trafficking patterns and the counter efforts being made by many governments in a keynote speech here to the Third Regional Conference on Substance Abuse.

She said that many believe North America has the worst drug abuse problems, but that is not entirely true.

Western Europe is also "an incredible target" for heroin, cocaine, cannabis, and psychotropic drugs.

And while North Americans and Western Europeans think they alone are victims of drugs from Asia, the Middle East, and South America, these same areas are victims of a huge traffic from the West of legal and illegal psychotropic drugs.

Ms MacLennan said that police and customs agents in the developed countries are increasingly trained to spot drug smugglers. "But a border guard in a poor country is not going to be able to spot diazepam dressed up as vitamin C."

Police and customs officials in poor countries are not trained, and cannot be trained under the circumstances, to distinguish such smuggling.

As for the fallout from trafficking, the Caribbean Islands, for example, are being crippled.

"They are not prepared for the kind of criminals, the kind of rich and sophisticated traffickers who are going through there on their way to North America to meet our demand for cocaine," she added.

Traffickers move swiftly in the face of adversity: a drought in the Golden Triangle area of Asia which drastically cut heroin supplies was soon compensated for with increased supplies of heroin from the Middle East.

Trafficking routes switch with the political wind: the revolution in Iran, or a decision by Turkey to come down hard on smuggling, which switched some supply routes down through Egypt. A result? An increase in heroin problems in the land of the Pharaohs.

Ms MacLennan said many countries, including the US and Canada, are now going after the big-time traffickers. "These are the people who launder their money through super Swiss banks, live happily in their huge houses, and attend Chamber of Commerce meetings. They are quite the civilized citizens, and their drug money is hidden."

Video-game arcades attract drug dealers

NEW YORK — Many video-game arcades are being used by drug pushers, says a report by the New York division of substance abuse services.

Douglas Lipton, deputy director of the division, told **The Journal** a survey was made of arcades; record, candy, and pizza shops; and other businesses where video games are a secondary source of income. Experienced observers played the games, and observed activity from 8 am to 11 pm.

Marijuana was available at 66 of the 102 sites studied, cocaine at 40, pills at 27, and heroin at 25.

Most selling was in video arcades. Mr Lipton says there was little or no drug-related activity in arcades that had either a uniformed guard or supervisor on duty.

Mexico-US collaborate

WASHINGTON — Scientific cooperation to combat alcohol abuse has been agreed to in a bilateral treaty between the United States and Mexico.

Under the agreement, the two countries will exchange information, scientists, and technicians. Studies will range from biochemical investigations to cross-cultural research.

A joint steering committee will meet alternately in each country to review the status of cooperative ventures, and provide advice to the governments on implementing the agreement.

Creditors? Play to the crowds, dear boy

By Wayne Howell

My dearest nephew:

How pleased I was to receive your missive in this morning's post, and how flattered I was that you solicit your old uncle's advice. You are like a son to me, and my only regret is that I cannot advise you with the elegance and wit with which Lord Chesterfield advised his son on wordly matters. But notwithstanding my stylistic infelicities, I shall do the best I can.

I am truly aggrieved to hear about your troubles at Breakstone Manor. I take it you feel the hot breath of your creditors upon your neck but they have not yet got you by the throat. However, I do agree that it is not an auspicious sign that the first- and second-mortgage holders have engaged an architect to draw up plans for a condominium development with the manor house as a communal "recre-centre."

It would truly be a tragedy if your fine institution dedicated to the rehabilitation of the alcohol-addicted were to be seized and used for base commercial purposes, expecially when the prospect of third-party payments is so tantalizingly near, and, if you get the accreditations you seek, you stand to make a bundle.

The basic problem, as I see it, is that neither you nor Breakstone Manor have the proper mystique. To put it bluntly, dear nephew, your program lacks pizazz, and you as its director, lack charisma. Your program is as commendable as any on the continent, and its results are about as good as one could expect. But just about any decent soap will get hair clean: the shampoo that sells is the one concocted out of exotic materials — herbs, peach-pits, avocado-skins, or whatever — with a balanced pH and proteins of one kind or another.

Do you get my point? You have to build a better mousetrap, dear nephew, if you expect the world to beat a path to your door. No new mousetraps to invent? Balderdash.

Why, just the other day, I was reading about one of your colleagues who has a whole new theory about addictions, based on the hemispheres of the brain. According to her, people who are right-brain dominant have trouble finding acceptance and appropriate avenues of self expression in our left-brain dominated society which stresses regimentation and compartmentalization.

These right-brain dominant people have greater facility for transcendent experiences and they get "hooked" on the intensity of peak experiences, and turn to chemical means to recreate them because they lack adequate means to develop and integrate them. So what they need are therapists who will work with them as they are, and facilitate their self-generated growth to a higher level of functioning.

Greek to you, nephew? Perhaps. But this act appears to be playing to good crowds and I am sure that if you had a similar thespian thesis Breakstone Manor would be turning away clients by the droves. Like the automobile salesmen say, dear nephew, you sell the sizzle, not the steak.

Now I'm not suggesting that the right/left brain dichotomy should be *your* sizzle. That has obviously been spoken for. But not to worry, the brain is a truly wondrous organ and the functions of various parts of it have only tentatively been delineated. So all you have to do is pick some functionally-obscure part of it, elaborate a theory, and you are in business. Breakstone Manor is in business too, of course, for only at Breakstone Manor will your unique insights be enshrined in a comprehensive treatment program.

What part of the brain to pick? I am of two minds on this matter. The pineal body attracts me for a variety of reasons. No-one knows what the damn thing is for, but there is general agreement among embryologists and neuroanatomists that it is a vestige of the parietal eye — the so-called "third eye" — of primitive reptiles. Who could resist "Third Eye Therapy?" Naturally this will be contracted down to TET therapy, for not only does it form a natural acronym, it also forms a delightful French pun. (In view of this you might even consider going lower-case with it, in the manner of *est*.)

Notwithstanding the virtues of *tet* therapy, I think you should also consider the possibilities inherent in the limbic system. The limbic system has some strangely named components, such as the "uncus" and the "hippocampus," and no-one really knows what this system is up to, other than the fact that it deals with pleasure and pain and sex. (Surely you can elaborate an impressive theory out of that mix, dear nephew.)

As I said, I am of two minds on this matter. My right brain, the intuitive creative feminine part of me, favors "Third Eye Therapy" but the cold logic of my calculating left brain favors "Limbic Systems Analysis." Who could resist that — it sounds like you are going to be cured by computers and computer experts.

These seem like the best possibilities, but there are others: there is a lot of weird stuff that goes on in the temporal lobe and perhaps you might wish to stake out your claim to fame in that area. The important thing is that you come up with a hot new theory that will put you and Breakstone Manor on the map.

You need not let this theory of yours get in the way of the Breakstone Manor program which, I understand, simply puts clients into a green and pleasant environment for a few weeks, and lets them meet and talk with others with similar problems under the direction of your staff. A certain number of clients are going to be helped by that atmosphere no matter what, and, who knows, perhaps even more will be if they are exposed to some mumbo-jumbo about seeing their problems through their third eye or getting their hippocampus into better communication with their uncus.

Develop your mumbo-jumbo dear nephew, and you shall banish those condo-developing wolves from the door of Breakstone Manor forever.

Your loving uncle

NEWS

Women on both drugs need monitoring

Pill may heighten Valium's effects

ORLANDO, FL — Women who simultaneously take low-dose estrogen birth-control pills and diazepam (Valium) may be at risk of sluggish reflexes from diazepam over-sedation in situations requiring mental alertness and physical coordination.

The reason for this appears to be seriously-impaired diazepam clearance from the body in the presence of 'the Pill,' Darrell Abernethy told the annual meeting here of the American Society for Clinical Pharmacology and Therapeutics.

Dr Abernethy, professor of psychiatry and medicine at the Tufts-New England Medical Center in Boston, said pilot data strongly suggest "that low-dose estrogen oral-contraceptive use markedly prolongs the elimination half-life of diazepam and significantly impairs its total metabolic clearance."

As a result, diazepam concentrations continue to build up in the plasma of women on oral contraceptives who also regularly use the benzodiazepine.

"Although a direct relationship between diazepam plasma concentrations and clinical effect is not clearly established, patients receiving both drugs should be monitored carefully for the possibility of increased diazepam effect," Dr Abernethy said.

"It is possible that changes in diazepam dosage may be required in patients who concurrently take both medications."

Dr Abernethy and colleagues have previously shown that the clearance of antipyrine — a drug which, like diazepam, is metabolized through oxidation in the liver — was significantly impaired in the oral-contraceptive user. The antipyrine studies led the Boston researchers to speculate the same phenomenon may occur when the birth-control pill user takes diazepam.

"We thought such a study could have important clinical implications because of the widespread use of both drugs," Dr Abernethy said.

To test their hypothesis, investigators compared a group of eight healthy volunteers taking low-dose estrogen birth-control pills for a minimum of three months, to eight healthy control subjects who were not on the Pill. The subjects were matched for age and weight, two important factors in determining rate of drug clearance.

All the women received a 10 mg intravenous infusion of diazepam and daily blood samples were drawn for a period of seven days.

The results showed that while the volume of drug distribution was similar in both groups, diazepam elimination half-life was 70 hours in the oral-contraceptive users compared to 47 hours in the non-users. And the total metabolic clearance was significantly less in the Pill group compared to the controls — 0.27 versus 0.45 ml/kg per minute.

Abernethy: changes needed?

Binding studies showed that drug plasma binding was the same in both groups — an important observation, Dr Abernethy says, because it is known that estrogen-containing oral contraceptives can affect the binding of a variety of drugs.

Although a single intravenous dose of diazepam was used in this study, Dr Abernethy says he believes the results can be extrapolated to oral diazepam use. Previous studies by his group showed that diazepam taken orally is rapidly absorbed and is completely bioavailable within a short period of time.

"We feel . . . the change in diazepam clearance with the single intravenous dose would translate itself into increased, steady state plasma levels of diazepam and its metabolite in the low-dose estrogen oral-contraceptive user (who also regularly takes diazepam)."

Dr Abernethy says he doesn't know how low-dose estrogen birth-control pills impair diazepam clearance. But there is a clue from animal studies. When estrogen is administered to laboratory animals, the liver produces decreased amounts of the protein cytochrome-P450. It is believed that this protein plays a key role in the hepatic metabolization of diazepam.

Peptic ulcer disease linked to tobacco use

By Harvey McConnell

WASHINGTON — Peptic ulcer disease among alcoholics is not a male prerogative — contrary to findings in the general public — and the condition is probably more related to cigarette smoking than alcohol consumption.

It was found in a study at the Mayo Clinic, Rochester, Minnesota, that among alcoholics, 16.3% of the 98 men, and 13.2% of the 53 women had peptic ulcer disease.

The researchers noted that the findings were in agreement with previous studies of alcoholics. However, most were done predominantly in males, they added in their poster presentation at the annual scientific conference of the American Medical Society on Alcoholism here.

There has been a rather dramatic increase in the rate of peptic ulcer disease in the general population in the United States and it has been stated that men have a two to three times higher rate than women.

The researchers said their study did not bear this out.

The report noted that 74.8% of the alcoholic patients were smokers at the time of admission, 11.3% were previous smokers, and 13.9% had never smoked.

The group of men and women with ulcers consumed far more cigarettes than the non-ulcer group. Alcohol intake per day was slightly less among ulcer patients (178 grams vs 197 grams) but there were such wide deviations that there was no significant statistical difference.

The Mayo researchers concluded that peptic ulcer disease may be more closely related to smoking than to alcohol intake.

Male beer drinkers are highest risk group

WASHINGTON — Men who drink beer are more likely to have drinking problems than men who consume other alcoholic beverages.

At the same time, beer drinkers are more likely to drink alone, and in the home.

These are among the findings of Dr John Hermon and colleagues at the Veteran's Medical Center, Boston, and presented at the annual scientific conference here of the American Medical Society on Alcoholism.

The men studied are among the 2,280 accepted for inclusion in the Normative Aging Study in the 1960s, a long-range epidemiological investigation which is continuing.

The particular study has looked at consumption of beer, wine, spirits, and liqueurs; the frequency; and the settings. Among the 1,517 questioned, 39% were beer drinkers, 13% were wine drinkers, 45% were spirit drinkers, and 3% were liqueur drinkers.

The beer drinkers were found to consume more alcohol and have more problems. Men who drink wine predominantly are more likely to drink in a family and home setting. Men who drink spirits are like beer drinkers and are less likely to drink for salutary reasons.

RESEARCH UPDATE/ Austin Rand

Self-help successes

There is a good deal to be said for using self-help manuals in programs for giving up smoking and controlling problem drinking, suggest two recently published studies. The first study, carried out by a research group at the University of Western Ontario, involved 40 smokers who wanted to quit. Average age was 39 years, mean years of smoking was 22, and mean smoking rate was 28 cigarettes per day. All but eight of the smokers had previously attempted to quit. After an introductory session, 18 smokers were given one manual, and 13 another one; the researchers judged both manuals to be sound and well-grounded in research. The remaining nine smokers were placed on a "waiting list" and strongly advised to quit smoking in the meantime. Follow-ups at three months and six months showed that while not a single person on the waiting list had quit, four out of 15 using the first manual had quit after three months and 5/15 had quit after six. (Three subjects had been lost to follow-up.) Of those using the second manual, the three- and six-month quit rates were 2/13 and 3/13. Given encouraging success rates, and low expense, the researchers say that there is a wide range of research to be conducted to determine which smokers are most responsive to manuals, and how manuals can best be combined with other forms of therapy. In a study of manual use with problem drinkers, a United States research group has found that drinkers receiving weekly, therapist-guided, individual sessions did no better, after 10 weeks of therapy and follow-up at six months, than did drinkers working on their own with a self-help manual and a supply of self-monitoring data cards which they returned to the clinic on a weekly basis. At six-month follow-up, 80% of the therapist-directed and 87% of the minimal-contact drinkers were judged improved. Seven per cent of the first vs 19% of the latter group had become abstinent.

International J of the Addictions, 1981, v.16: 1233-1239 and 1247-1254

Kids consuming caffeine

Ninety-eight per cent of children and teenagers in the United States get some caffeine everyday, indicates a cross-sectional sampling involving 1,135 US kids aged five to 18. The overall daily average was 37.4 mg. Considering only days on which some consumption of caffeine occurred, as indicated by a seven-day food diary each youngster kept, the consumption of caffeine went as high as 375 mg and averaged 47.9 mg. The greatest source of caffeine was tea, which accounted for 34.2% of total intake, followed by carbonated drinks (26.4%), coffee (22.1%), and chocolate, and food containing chocolate (17.3%). The study was carried out by Karen Morgan and colleagues at the department of nutrition, Michigan State University, East Lansing.

Federated American Societies of Experimental Biology, annual meeting: April 1982

Say please and I'll stop

How a non-smoking sign is worded has an effect on the likelihood of compliance, indicates a study which describes the effects of no non-smoking signs, vs sharply-worded injunctions against smoking, vs more pleasantly-worded signs. The scene of the study was the lobby of a United States Veterans Administration Medical Center. The "negative" signs said: "No smoking — offenders subject to fine" and "Hospital smoking policy strictly enforced." The "positive" signs said either "Please do not smoke" or "Consider others' health, do not smoke." Observations of the proportions of people smoking in the lobby under the three different sign conditions showed that while 29% of those using the lobby smoked when there were no signs, this dropped to 11% with negative signs, and to 5% with positive signs. Women seemed to be particularly affected by the more courteously-worded signs. The proportion of men smoking when faced with the different signs dropped from 37% to 15% to 7%. At the same time, the proportion of smoking women dropped from 8% to 3% to 0%.

International J of the Addictions, 1981, v. 16: 1467 to 1471

Alcohol and breast cancer

Alcohol consumption can contribute to the development of breast cancer, indicates a large-scale study of factors distinguishing women with breast cancer from women hospitalized for a number of other diseases. The study, headed by Lynn Rosenberg and co-workers at Boston University School of Medicine Drug Epidemiology Unit, found that women who drank alcohol had a breast cancer rate 1.5 to 2 times greater than did women who had never been drinkers. Risk increased with the amount consumed, with women drinking four or more times weekly having a risk 2.0 to 2.5 times higher than never-drinkers. Controlling for a wide variety of factors that are known to be associated with elevated breast cancer risk (such as cigarette consumption and any personal or family history of breast disease) did not dispel the relationship between alcohol consumption and breast cancer. The authors grant that dietary factors — on which they had no information — could underlie the apparent effects of alcohol consumption. However, the possibility that diet was the real culprit was put in doubt by the fact that women who had stopped drinking — but had presumably not changed their diet much in other ways — had a breast-cancer risk only slighter greater than the never-drinkers.

The Lancet, 1982, v. 1: 267-270

Psychiatrists on the wagon

Britain's Royal College of Psychiatrists' position on drinking alcohol during pregnancy was, only four years ago, summed up by the statement that "two bottles of wine a day was getting into the danger area." The British psychiatrists have now radically changed their official view. "Even very moderate social drinking may be associated with decreased birth weight, and increased risk of spontaneous abortion," the Royal College says, adding that moderate drinking may result in some degree of deformity in the fetus. The bottom line of their advice now is: "women would be well advised not to drink alcohol during pregnancy."

The Lancet, 1982, v.1: 636

Anti-hyperactivity Rxs raise Tourette risk in children

By Austin Rand

NEW HAVEN, CT — Children who take stimulant medication for relief of hyperactivity or attention deficit disorder (ADD), are at increased risk of developing Tourette syndrome, says a Yale University School of Medicine research group.

The syndrome, first described in 1885 by French physician Gilles de la Tourette, involves violent physical and vocal tics, including grunting, barking, and often, coprolalia — repetitive streams of "dirty" words.

The syndrome is believed to afflict only about one person in 2,000, estimates the New York-based Tourette Syndrome Association, but on the North American scale that means more than 100,000 people. It usually hits first in childhood, between ages four and 13 (mean age seven) and more than three-quarters of sufferers are male.

Symptoms get worse initially, in frequency and severity, but then stabilize in the teenage years, and wane irregularly in adult life.

The syndrome is believed to have an organic basis since it regularly responds to haloperidol, a strong tranquillizer which came on the market in the 1960s, but not to any other medication.

The Yale research group, led by Dr Thomas Lowe, reports its findings on the relationship between stimulants and some cases of Tourette syndrome in the March 26, 1982 issue of the *Journal of the American Medical Association*.

In 100 Tourette cases evaluated by the group during a several year period, 15 indicated that the onset of the syndrome was a response to the child starting stimulant medication for hyperactivity or ADD.

"It isn't clear yet just what it is that goes wrong when some hyperactive children start taking stimulant medication," Donald Cohen, one of the researchers, told **The Journal**. "But there is evidence that the stimulants alter receptor functioning and increase formation of catecholamines. In a vulnerable child, the result can be onset of tics, worsening of tics that are already present, or, in some cases, the start of Tourette syndrome."

The Yale researchers have estimated that, of children taking stimulants, about one in 1,500 will develop the syndrome.

"My sense is that three or four children will develop facial tics on stimulants, and a few of those will go on to develop the full-blown Tourette syndrome. Even if it's only one in 2,000 who ultimately develop the syndrome, that amounts to a lot of children if you remember that there are several hundred thousand children who, every year, are receiving stimulant medication," says Dr Cohen.

It has not been possible to define any threshold, he adds, emphasizing that "neither tics nor Tourette syndrome are definitely something produced only by large amounts of stimulant."

If either tics or Tourette syndrome appear in the family history, stimulants should not be given, the researchers advise, and if the child shows tics, stimulant medication should not be started, or should be discontinued.

"Unless doctors are aware that the tics could be a side-effect, they might actually increase the dosage, and that, in some cases, can bring on the syndrome," says Dr Cohen.

GILBERT

'. . . cigarette consumption could be considerably reduced by making cigarettes denser again . . .'

Another way to reduce cigarette use

By Richard Gilbert

Last month I reported on the relationship between the price of cigarettes and their consumption. I argued that a sure way of reducing cigarette use in Canada would be for governments to raise taxes enough to cause a large increase in the retail price of cigarettes. Specifically, I suggested three phased increases that in the course of a year would double the price of cigarettes to $2.50 a pack and reduce cigarette consumption by half.

I presented two graphs with last month's column. One showed an almost relentless increase in per capita cigarette consumption by Canadians during the past 33 years. In 1949, 1,252 cigarettes were bought for every man, woman, and child. In 1980, the average was 2,739, an increase of 119%. During the same period the price in constant (1982) dollars fell from $1.70 to $1.23, although less smoothly than consumption had increased.

This huge increase in per capita cigarette use begs two important questions:

1. How does it square with all the reports that cigarette use in Canada is on the decline?
2. Was the increase caused wholly by the reductions in real prices, or were there other, possibly more important, factors?

Prevalence down

The prevalence of smoking is certainly on the decline. According to regular surveys conducted by Health and Welfare Canada, the proportion of daily cigarette smokers in the population older than 14 years of age fell from 45% in 1965 to 34% in 1979. (A different, more comprehensive federal government survey suggests that the actual proportion of regular smokers in 1979 may have been 37%; but there seems little doubt that the prevalence of smoking has declined.)

What has happened, obviously, is that the people who smoke have been smoking a lot more. Reliable figures on the prevalence of smoking do not seem to be available for the whole of the period 1949 to 1980. For the period 1965 to 1979, it appears that the number of cigarettes smoked per smoker rose by 17%, from 26.5 to 31.1 per day.

Thus, at least for the second part of the period, the relentless increase in per capita cigarette consumption can be squared with reports of declines in cigarette consumption by noting the simple fact that smokers are smoking more.

Why are smokers smoking more? It could be merely that cigarettes have become relatively less expensive, enabling smokers to indulge their habit to greater excess for a given outlay of funds. The careful analysis of the relation between consumption and cost of cigarettes that I referred to last month leads to the conclusion that price changes can account for only part of the huge increase in consumption between 1949 and 1980. Specifically, of the average increase in consumption of close to 2.5% a year during this period, only about 0.5% a year can be attributed to declines in real price. Some other factor or factors must have caused the remaining average increase of 2.0% a year.

Puffing and fluffing

A likely cause of the increase in cigarette consumption by smokers is the general 'weakening' of cigarettes by manufacturers that has been going on during the past few decades. In 1968, for example, the average cigarette sold in Canada yielded 21.1 milligrams (mg) of tar to a standard smoking machine. A decade later the average tar yield was 15.0 mg, a decline of 29%. Nicotine yields fell by a similar proportion.

Most of the reduction in tar and nicotine yields has been achieved by processing the tobacco in such a way that cigarettes can be made with less of it. The tobacco is literally puffed and fluffed, so that a given-sized tube of cigarette paper can be held firm by a smaller amount of tobacco. As a result, other things being equal, less tobacco is being burned in each cigarette. Cigarettes burn more quickly than they used to. Tar and nicotine yields are lower.

There are no good data on the average tobacco weight of Canadian cigarettes. In the United States, the amount of tobacco per cigarette began falling in the early 1950s. It fell by 15% from 1950 to 1960, by a further 14% from 1960 to 1970, and by a further 13% from 1970 to 1980. Because tar yields per cigarette have been falling at approximately the same rate in the US as in Canada, it may be safe to say that the tobacco content of cigarettes has declined similarly in the two countries.

How might the lightening of cigarettes have caused smokers to smoke more? There are at least two ways. One is that cigarettes may have become less satisfying. Smokers smoke more to get the same overall effect. The other is that lighter cigarettes may have fewer toxic effects, enabling smokers to smoke more often without getting ill. Perhaps both things have been happening.

It is also conceivable that neither effect has caused the increase in cigarette use per smoker. Smokers could be smoking more because the world has become a more stressful place during the past three decades, or for some other reason. The reduction in the tobacco content of cigarettes may be a coincidence. This is unlikely. Experimental studies have shown that cigarette consumption increases when the tar and nicotine content of cigarettes is reduced. It is reasonable to extrapolate from these studies and conclude that the most important cause of increased cigarette use since 1949 has been the reduction in the weight of tobacco in the average cigarette.

More profit

Indeed, if the startling graph of cigarette consumption from 1949 to 1980, published here last month, had instead shown per capita weight of tobacco purchased as cigarettes, much of the graph may very well have been flat, particularly the part for the later half of the period.

It follows that the striking change in smoking behavior evidenced during the past few decades has been not so much an increase in the number of cigarettes smoked by the average smoker as an increase in the way in which the daily dose has been delivered. Two or three decades ago, the average smoker smoked about an ounce of tobacco a day divided up into about 20 one-cigarette fixes. The average smoker still uses close to an ounce of tobacco a day, but now it is divided into 30 fixes. Incidentally, although the price per cigarette has declined in real terms during the past few decades, the cost of the habit may very well have increased. Thirty cigarettes today cost even more than 20 cigarettes cost in 1949. Thus, by weakening cigarettes, manufacturers have found a way of wringing more profit out of a given amount of tobacco. Governments, too, have benefited by the trend to weaker cigarettes, because cigarette taxes are based mostly on the number or the value of the cigarettes rather than on the weight of tobacco in them.

If this is all true — and I must stress that the data are not yet complete — cigarette consumption could be considerably reduced by making cigarettes denser again. If cigarettes were made stronger again, it is likely that fewer of them would be purchased and smoked. Whether this would be a good or a bad step from the point of view of the health of Canadians is very much a matter of dispute.

In all the research that has been done on the relative hazards of smoking weak and strong cigarettes, only one thing stands out clearly. Smoking light cigarettes is less often associated with lung cancer than smoking cigarettes that yield high levels of tar and nicotine. For many other hazards, including chronic obstructive lung disease and the adverse results of smoking during pregnancy, the relative effects of strong and weak cigarettes are just not known. For the most important adverse consequence — coronary heart disease — some of the data suggest that smoking weaker cigarettes may be associated with higher risk of the disease. Other, equally valid data show reduced risk or no difference in risk.

How could switching to low-tar cigarettes actually increase the risk of heart disease? If the switch means an increase in the number smoked, and an increase in the intensity of inhalation, the total load on the body of some of the hazardous substances in tobacco smoke can be increased. Of particular concern are nicotine and carbon monoxide, both of which have adverse effects on the circulatory system. Carbon monoxide yields of certain low-tar cigarettes may be further increased by "hole-blocking," whereby small perforations near the filter, introduced to dilute the tobacco smoke drawn into the mouth, are consciously or unconsciously covered by the smoker's fingers while inhaling.

Cynical view

Cigarette smoking is believed to cause more mortality from heart disease in Canada than it does from all other causes of death put together. For example, it has been estimated that in 1974, among Canadians aged one to 70 years, cigarette smoking caused 4,531 deaths from heart disease, 2,655 deaths from lung cancer, and 1,532 deaths from other causes — the total being 8,718. If further research shows that smoking light cigarettes is indeed associated with increased heart disease, the higher incidence of which more than offsets the decline in deaths from lung cancer, then the remarkable trend to light cigarettes evidenced during the last three decades will have been an adverse trend from the point of view of public health.

Moreover, the marketing of light cigarettes may have contributed to increased smoking by young people, particularly young women. Experimental studies suggest that girls are especially likely to succumb to strong social pressures to smoke if weak cigarettes are available.

A cynical view of the cigarette industry is that it has pushed low-tar cigarettes to ensure increased consumption in a shrinking market, and to maintain a flow of new customers, all the while parading the pushing as a public health measure. However, it should be stressed that although we can be reasonably sure that consumption would fall below what it otherwise would be if cigarettes were made stronger again, we do not know whether the health of the population would be better or worse as a result.

Next month: The drug scene in 1992.

NEWS

Feds shunt long-awaited funds to Canadian native programs

By Pat Ohlendorf

TORONTO — A major commitment to help Canadian Indians combat alcohol and drug problems has been announced by the federal government.

During the next five years, $154 million will be spent to establish a new Native Alcohol and Drug Abuse Program (**The Journal**, March).

Minister of Health Monique Begin, and Minister of Indian Affairs and Northern Development John Monroe, who announced the program jointly last month, acknowledge alcohol and drug abuse as the most serious health threat to native people.

"The National Native Alcohol and Drug Abuse Program represents a significant commitment on behalf of government to respond to this major health and social problem," Ms Begin says.

"For the first time we will have a permanent and adequately-funded program to support our native people in their efforts to prevent and treat alcohol and drug abuse problems in their communities."

The program will be a major step toward "increasing the level of health in Indian communities to a standard enjoyed by other Canadians," she adds. To do this, the government will support projects initiated and run by communities themselves.

The new program takes off from an earlier federal program for alcohol abuse, which was funded for only $3 million over a seven-year period, and ended March 31.

The new program will deal not only with alcohol, but with drugs, solvents, and other chemicals.

It will increase the number of treatment centres for Indians and Eskimo people across Canada from the present eight centres to 30. It will reach 90% of Indian reserves, from the present 35%, increase in-patient beds from 140 to 730, and increase the number of trained native alcohol and drug workers from 300 to more than 800.

In addition, Ms Begin has singled out specific groups for whom programs will be developed.

Women, she says, are "particularly vulnerable to becoming direct or indirect victims of drug and alcohol abuse." Native women's groups will be important in running prevention and treatment services and special approaches will be made for pregnant women.

Children and adolescent natives, she continues, are susceptible to alcohol and drug abuse and need help in understanding and handling the problem.

To keep the minister advised, a national council on native alcoholism and drug abuse will be set up. The regional boards established under the previous program will continue.

Of the total $154 million, about 40% will be spent on prevention programs, 26% on treatment, and the remaining 34% for training, research, administration, and capital costs.

"We realize that this program is only part of the solution to alleviating the problem of alcohol and drug abuse. Ultimate success depends upon improving the way of life in our native communities," Ms Begin says.

As a step in that direction, the government recently committed $345 million for native economic development for the next three years.

"Only through a comprehensive strategy involving the efforts of several federal departments and various levels of government will our native people become self-reliant in all aspects of life, including health," Ms Begin says.

Begin: 'it's a significant commitment to native people.'

NWT anxious to move on 'catch-up' projects for drug prevention

TORONTO — This is what we've been fighting for, for seven years, and the government finally listened," says a Northwest Territories (NWT) official about Ottawa's recent announcement of a $154 million infusion into native alcohol and drug abuse programs.

"When you have to cover the largest area in Canada with only $282,000 for alcohol abuse — which was our budget last year — you don't get very far," Al Wilson, regional consultant in Yellowknife for the federal Native Alcohol Abuse Program (NAAP) told **The Journal**.

Last year, that amount funded only six federal programs in the entire Northwest Territories. "We're so far behind the rest of Canada it's pitiful," says Mr Wilson.

But he's hopeful that this time the NWT won't get the "tail end" of the federal money. "I've been told they're looking very closely at the geographical difficulties and the high cost of living here, so we may get a fair shake out of it."

If Ottawa sends between $750,000 and $1.25 million to Yellowknife, then "we can really get going and do things that should have been done five years ago."

The major need in the NWT, says Mr Wilson, is for many more trained native workers in the prevention and treatment of alcohol and drug abuse. In addition, four prevention projects are ready to roll as soon as funds come through: one in the eastern Arctic, one in the Beaufort Sea area, and two in Yellowknife. Four others are in the planning stages.

Bootleggers and liquor store are central issues

Northern town takes on territorial government

TORONTO — An attempt to cut down bootlegging in Inuvik in Canada's far north by rationing purchases from the government liquor store has provoked an angry clash between the Northwest Territories government and Inuvik city council.

Inuvik, just south of the Beaufort Sea, has a population of around 3,000 people. The government liquor store serves the town and surrounding area.

A case was to go before the Supreme Court of the Northwest Territories (NWT) late in April to determine whether the territorial government in Yellowknife has the power to impose restrictions on the sale of alcohol in this northern outpost.

Last February, George Braden, minister of justice and public services for the NWT, brought in restrictions preventing people from buying more than 40 ounces of hard liquor or wine, or two cases of beer per day. The purpose? To crack down on the flourishing bootlegging trade. Bootleggers had been purchasing large quantities of liquor at the Inuvik store and selling it at great profit in other towns which do not have liquor stores.

David Miller, executive assistant to Mr Braden told **The Journal** a bootlegger can get $35 to $50 for a $12 bottle of hard liquor.

"Mr Braden imposed the restrictions because the people in the surrounding area put pressure on him to do so," says Mr Miller.

"And afterwards, the leaders of every outlying community in the Beaufort Sea area, except Inuvik, sent letters of support, as did the leaders of the Dene Nation (the elected government of the Indian people in the NWT)."

The restrictions are not an attempt to control individual drinking, Mr Miller emphasizes.

"Anybody who drinks 40 ounces of liquor a day or who has that requirement is most definitely an alcoholic. The restrictions are an attempt only to stop the bootlegging."

It's difficult to apprehend bootleggers, continues Mr Miller. They can't be arrested at the liquor store because there's no way to prove they're going to bootleg, even if they say they are.

"You have to actually catch them doing it. And the region is very large — there are all sorts of quiet places to land a plane."

Nellie Cournoyea, legislative assembly member for the NWT who lives in Inuvik, was one of those applying pressure on the government to take action against bootlegging.

"The people in the communities around Inuvik (like Ft McPherson, Arctic Red River, Aklavik) are not dry, but they really don't want large amounts of liquor in their communities," Ms Cournoyea, who is part Inuit, told **The Journal**.

"They figure they can handle the (alcohol) problems if they don't have easy access to liquor. A bootlegger taking crates of liquor into a community of 200 or 600 just raises heck in the community for a while."

The legal question pivots on who has the right to impose restrictions on alcohol sales. The ministry of justice in Yellowknife contends it has the right because the liquor store is a government store. But Inuvik town council argues the town has the right because the store is in Inuvik.

"We're taking this to court because the people of our town should have the right to vote before such a change is made," Douglas Billingsley, acting mayor of Inuvik, told **The Journal**.

If the council wins its case, he says, "we'll have a plebescite and we'll abide by the outcome. But we're certainly not happy to have this imposed from the outside."

"It's just petty politics," counters Ms Cournoyea. "This thing has been going on for three years. The Inuvik town council hasn't been able to decide what to do about the bootlegging and now that someone else has decided it for them, they're mad."

But while Mr Billingsley says the main point is who should make the decision to ration, he also contends restricting liquor sales has had a detrimental effect: it has increased the use of dangerous substitutes.

"There has been no decline in the volume of sales in the liquor store in the period it has been under rationing," Mr Billingsley says.

"The people with the dollars are just paying higher prices and those who don't happen to have the dollars are having to resort to very unhealthy subsitutes."

He says there has been an increase in the sales of shoe polish, shaving lotion, lysol spray, gravol, and vanilla extract since the restrictions began.

"We're going to have deaths out of this yet," he predicts. "If they (Yellowknife) delay the court case until someone goes blind, that's got its own set of implications."

But Ms Cournoyea says the acting mayor is exaggerating. "They (some of the Inuvik council members) are just looking for excuses."

The population of Inuvik is about 55% native and 45% white. A Canadian Forces base near the town contributes substantially to the white population. Only one member of the town council is native. The others, say Ms Cournoyea and Mr Miller, mainly represent white business interests.

In contrast, the population of the regional towns affected by the bootlegging are almost exclusively native.

NEWS

Women are being bombarded with tobacco ads

By David Milne

SAN FRANCISCO, CA — Women's magazines are doing a "serious disservice" to their readers by carrying cigarette advertising which portrays smoking in a positive light, despite extensive medical evidence to the contrary, a University of San Francisco epidemiologist charges.

This deception has been perpetrated by leading women's magazines in the United States from the 1930s to the present, according to a survey by Virginia Ernster, PhD. The survey examined the extent of cigarette advertising, images in advertising, ad revenues received, number of ads per issue, and readership characteristics.

Dr Ernster says that during the past 10 years the tobacco industry has dramatically increased the number of ads in women's magazines with numerous new brands designed for the female market, and images of women who are "attractive, vigorous, and healthy."

She examined cigarette advertising volume for a 10-month period during 1981 in 13 leading magazines — *Better Homes & Gardens, Cosmopolitan, Family Circle, Glamour, Harpers Bazaar, Ladies Home Journal, Mademoiselle, McCalls, Ms., Redbook, Vogue, Woman's Day,* and *Good Housekeeping.*

Of these, only *Good Housekeeping* carried no cigarette ads because "its seal of approval can't endorse the negative aspects of the product," says Dr Ernster. For the others, the average number of pages devoted to cigarette ads ranged from five to 16 per issue.

Dr Ernster says she and other specialists in cancer control are concerned because, "lung cancer will soon surpass breast cancer as the number one cause of cancer death among American women, and this preventable epidemic is due to cigarette smoking."

"Women constantly are bombarded with a mixed message about smoking," she says. "The positive images conveyed in cigarette promotions are contrasted with continuing reports in the medical literature about negative disease risks facing women who smoke."

Medical reports present the other side of the picture.

One problem follows another

Teens' drink patterns help predict drug use

By Harvey McConnell

WASHINGTON — Alcohol abuse patterns among teenagers can help investigators predict their drug use patterns, and problems.

"Our data is clear on that," says James Halikas, director of the Wisconsin Alcoholism and Drug Abuse Research Institute, and also director of the division of alcohol and chemical dependence, Medical College of Wisconsin.

Dr Halikas says that research among 910 boys and girls who went through the juvenile court system in Milwaukee in 1980 to 1981 shows that 14% had both alcohol and drug problems, 5% had alcohol abuse problems, and 16% had drug abuse problems.

What is surprising, Dr Halikas told **The Journal**, is that 12% of the young people, aged 15, used drugs in front of their parents, and 18% drank in front of their parents. "That might not sound too dramatic until you think: if you had a 15-year-old, would you let him go pop a beer in front of you?"

Dr Halikas says he and his colleagues had developed a differential assessment program "which we were going to make the model treatment for the 1980s but then funding from the National Institute on Drug Abuse was cut in February.

"Now we hope to come up with brief instruments which will be useful in clinical settings — such as among probation and parole officers, or school teachers — who can quickly assess what is the likelihood the kid has got alcohol or drug abuse problems, and thus allow early intervention."

Dr Halikas, in his report to the annual scientific conference of the American Medical Society on Alcoholism here, said the basis of their estimates were the number of life problems experienced by the young people they questioned.

Dr Halikas said they found that if the young person had a diagnosis of alcohol problems "he or she is twice as likely to have had parental breakup due to alcohol or drug problems, twice as likely to have a father with alcohol or drug problems, and twice as likely to have a father already in treatment.

"An additional point is that most of the parents are in the 30- to 45-year age range and still at an age of risk for alcohol problems."

Those with alcohol abuse problems, who also had problems with drugs in general, had tried at least five or more drugs. Dr Halikas said the drugs ranged from marijuana, to PCP and cocaine.

Those with drug abuse problems had a host of additional problems, from overdosing, to blackouts, to problems with the stomach. Ten per cent thought they were addicted to drugs.

Dr Halikas said there is increasing evidence "that there are some 13- and 14-year-olds who can't use anything without serious problems."

He and his colleagues have found that while many adults are trained to look for drug problems in young people, few are trained to look for those with alcohol abuse problems, and these are often not recognized.

Halikas: a host of additional problems.

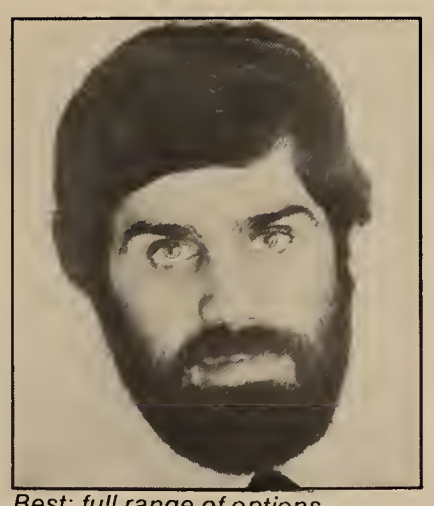
Public may never notice impact of recommendations

Ontario task force looks at smoking, health

TORONTO — An Ontario task force on smoking and health is emphasizing that systematic, government intervention is important in reducing cigarette use in the province.

Allan Best, chairman of the Ontario Council of Health Task Force on Smoking, says there is a "clear sense around the globe that government should become more involved in smoking and health. But, with the exception of Scandinavia, governments have tended to attack the problem in a piecemeal fashion.

"Our task force is considering a full-range (of government action)." A variety of options is probably more important than any single strategy, adds Dr Best, who is also a professor of health studies at the University of Waterloo.



Best: full range of options.

Although the task force is not ready to go public with its recommendations, Dr Best says that, in general, there are several options open to government to fight smoking: banning tobacco advertising, slapping on heavy taxes (see Gilbert, **The Journal**, April), increasing funds for smoking research and health education (in schools, the media, and the workplace), and banning smoking in public places.

Dr Best is unable to predict when, or even if, the public will notice the impact of the task force's deliberations. (The report is expected to be presented to the Ontario Council of Health, and if all goes well, to the minister of health.)

However, regardless of the ultimate fate of the report, Dr Best adds that it, and the continuing efforts of the task force "will serve as a catalyst to increase the amount of anti-smoking activity in the province."

Principals report students to police in schools' drug plan

OTTAWA — A new policy adopted by the Carleton Board of Education (CBE) here states that principals should turn over evidence of student drug and alcohol abuse to the police.

The policy affects approximately 75 elementary and secondary schools in a 1,100 square mile area bordering on the city of Ottawa. It requires teachers to report evidence to school principals for delivery to the police, and states parents must be called into any drug- or alcohol-related incidents involving students under age 19. The board's former policy left the decision to inform police and parents to school officials and applied only to alcohol use.

In the past, principals could suspend students for a first offence, but were required to suspend the students for a second one. The policy has added drugs to the list of offences justifying suspension, and requires a third offence be punished by a maximum 30-day suspension.

CBE high school principal and committee member Gordon Fenton says: "The policy now makes it very clear to students, staff, and parents where the board stands. We don't condone drug and alcohol abuse." He adds that there seem to be "creeping acceptance" in the community toward drug and alcohol use, and although the new policy is harsh, it now allows him to deal with problems as they arise.

Collecting evidence of drug and alcohol use in schools will be serendipitous since staff cannot legally search students or lockers. Essentially, a teacher will have to "happen" on the scene of a drug deal, or have "reasonable and probable grounds" to suspect a student is under chemical influence. Then a student will be sent to the principal with the "evidence" which will be turned over to the police for analysis. Any other disciplinary and/or legal action would follow.

Jean Beamish, CBE school trustee who chairs the policy committee, said a copy of the new policy will be sent home with every CBE student as a further deterrent.

"Our original alcohol policy was made clear this way and students don't bring mickeys onto school premises to sell. Now, hopefully, the won't bring drugs either," she said.

"The school is not a court of law, nor are principals or teachers policemen," said CBE trustee Harold Wilson. "The policy simply forces school staff to do some observing of what's going on in the school, and act to maintain order and discipline."

However, two former drug users who helped prepare the report on drug and alcohol abuse for the board disagree with the new policy.

Pam Scholey, recovered alcoholic and former drug user, and Noel Nadon, a worker with a local halfway house for chemically dependent youths, said discipline was not the answer to what they called a health problem. They both said peer counselling would be preferable to immediate police involvement.

Close to 80% of smokers have hazardous CO levels

WASHINGTON — Smoking is the most significant and widespread source of carbon monoxide levels in humans, and a majority of smokers have levels which are hazardous to their health.

A report by the United States department of health and human services says other primary sources of carbon monoxide are exposure from automobiles, industry, and within buildings.

Nearly 80% of the smokers studied had blood carbon monoxide levels potentially hazardous to their health. Among non-smokers, only 5% had potentially-hazardous carbon monoxide levels.

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Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Gretzky: what he does in his personal life is not the issue.

Parent wants fewer pics of drinking sports heroes

I am a concerned parent of three teenagers and hope **The Journal** can put some pressure on our national magazines about showing our sports heroes consuming alcohol.

After years of counselling my 16-year-old son, who is now playing All-Star Hockey, in the seriousness of drinking alcohol, he showed me a picture in a national magazine of Wayne Gretzky holding a bottle of beer. "See mom, it's OK to drink, even Wayne does it!"

Well, of course, what could I say at this point? I realize Wayne is of age, and what he does in his personal life is not the issue I'm trying to make. It's already been proven that little people imitate their elders.

I would like to use this as an example of another means of preventing the younger ones from starting to drink after seeing our national and world sports figures consuming alcohol in our publications.

I hope **The Journal** can make the news media start a trend and not publicize that it's A-OK to drink.

I've contacted two MPPs (members of provincial parliament) who agree with me, and say they will try to do something about this serious issue.

Please, do not misunderstand this letter. I'm not knocking our sports heroes — I'm trying to stop publications from showing athletes, etc, drinking.

If we can all get the younger generation *to believe* that alcohol is bad for the body, our future problems would be solved.

Please do not disclose my name.

A Concerned Mother
Ontario

World-wide goings-on

The Journal is excellent — keeps abreast of world-wide opinions and "goings-on."

D. Danard
Surrey, BC

Scientific smuggery a disservice to all

It was refreshing to see Dr Carlton Turner's comments about some United States scientists who have been guilty of what he called the "NIH-not invented here" syndrome (**The Journal**, April).

At the same time, it is a sad commentary that the reluctance of these scientists to accept the data and observations of their colleagues abroad have, in many cases, done a great disservice in a number of fields.

Certainly, Dr Nils Noya's findings about the devastating effects of cocaine in Bolivia, (**The Journal**, Feb, 1978), have come to pass with a vengeance in the United States.

It is not in the drug and alcohol abuse field alone that such things happen — such reluctance is evident in the medical field. A prime example is the recent announcement the US government is releasing new beta blocker agents for heart patients. It would have led the unknowing to believe that all the development and research was done in this country.

What was studiously ignored in the announcement was the fact that these drugs were first developed in Britain, and have been used there for nearly a decade.

Many other advances have taken place in Sweden, Finland, France, West Germany, Switzerland, and Britain which most Americans are unaware of.

I don't wish to put down US scientists, but if they were to drop some of their arrogance and listen intelligently to what their "foreign" colleagues have found, they would render an even better service to their profession as well as us, the general public.

Claus Peter Arndt
Washington, DC

The Journal is great says US expatriate

Recently, I saw **The Journal** for the first time. Surprisingly enough, I got my hands on it at my Italian AA (Alcoholics Anonymous) meeting, which struck me as being funny because no one there whom I know speaks or reads English.

I'm an American student studying veterinary medicine here in Italy at the University of Parma. I'm also a recovering alcoholic or addict, however it might be put, because I'm dually-addicted, for lack of a better term. It's been more than a year now since I've stopped.

Although I'm studying veterinary medicine, I've become interested in the physiological and psychological problems of addiction. For this reason, I'd like to begin subscribing to **The Journal**.

I'd like to congratulate you on a great publication.

Eddie R.,
Parma, Italy

MD applauds nurses' story

Congratulations on the excellent impaired nurses article (**The Journal**, Feb). We plan to use it as a reference to the many nurses groups that are developing from Millicent Buxton and Marty Jessup's initial efforts.

David E. Smith, MD
Haight-Ashbury Free
Medical Clinic
San Francisco, California

FEATURE

Austin Rand reports:

From King Tut to Islam, Egyptian epochs reveal leaders struggled to control alcohol use

TORONTO — The 5,000 year history of alcohol use in Egypt — from the time of the earliest surviving records and artifacts, to the imposition of Islamic abstinence — gives historical perspective to current understanding of alcohol.

It shows that, in some ways, things haven't changed much, says Nady el-Guebaly, head of psychiatry, St Boniface General Hospital, and associate professor of psychiatry, University of Manitoba.

Dr el-Guebaly has published a study of alcohol use in ancient Egypt in the *International Journal of the Addictions* (1981, v.16: 1207-1221) and spoke to **The Journal** about his findings.

For starters, possibly the world's oldest alcoholic drink can be traced back to pre-dynastic Egypt.

During the first Egyptian dynasties (3,400 - 2,900 BC), barley beer became a national drink, along with a beer made from spelt (a primitive form of wheat). However, available evidence indicates that temperance was the rule. Viticulture thrived, but use of wine was restricted, primarily to the highest levels of Egyptian society.

During the succeeding period, (the 800-year-long Old Kingdom 2,980 - 2,160 BC), intoxicants were considered "an occasional source of harmless pleasure," and beer shops are believed to have existed throughout Egypt.

The beer was made from grain which was kept wet until it began to sprout; it was then ground, made into a paste, and fashioned into partly-baked cakes. To prepare the beer, the cakes were broken up into pots filled with water and left to ferment. Once ready, the beer would last only a few days before going sour.

The next two periods, the Middle Kingdom (2,160 - 1,580 BC), and the New Kingdom (1,580 - 1,090 BC), which included the reigns of Queen Hatshepsut and the young King Tutankhamen, represented the apogee of Egyptian power.

"As the kingdom became more and more powerful, there was also an increasing acceptance of drinking. During this period, there are many references to the 'Day of Intoxication,' a monthly occurrence which was a culturally-accepted and delineated time when (Egyptians) could let go," says Dr el-Guebaly.

From the New Kingdom period there is also evidence of concern about alcohol abuse, and attempts to control alcohol sales by imposition of taxes: "the governmental practice of drawing important revenues from man's drugs is not new," comments Dr el-Guebaly.

A book of etiquette from that period, called *The Making of the Sribe Ani*, warns about the effects of excessive drinking. Drinking was common among students. The scribe Ani, history relates, was accustomed to receiving "three loaves of bread and two jars of beer daily" from his doting mother during the time that he was in school.

The medical use of beer and wine also contributed to increased consumption. All of the major medical papyri of the time mention such uses, for everything from indigestion to "female troubles." One papyrus, containing 250 prescriptions for practising physicians, listed no less than 27 in which beer was the method of delivering the medicine, and 12 which were based on wine.

The succeeding period, from 1,090 to 525 BC, is regarded as the beginning of Egyptian decadence, says Dr el-Guebaly. Widespread alcohol abuse is remarked on in surviving historical sources, and drinking is believed to have been an important part of a society-wide hedonism, although most of the material refers to the upper groups or classes.

Women, particularly in the upper classes, seemed to have had easy access to alcohol, and there are banquet descriptions which indicate they were encouraged to join in and "not spoil the entertainment."

A famous wall-painting from the period, Dr el-Guebaly notes, shows a lady "overcome by too much wine; vomiting, and being helped by her servant." Over the lady's arm is bent a lotus flower, symbolizing intoxication.

"It is important to remember that women in Egyptian society of this time had access to positions of power. It is not surprising if there was access to other things too, such as alcohol," comments Dr el-Guebaly.

After 525 BC, Egypt came under the control and cultural influence of a number of invaders, including the Persians, Greeks, and finally, in 30 BC, the Romans. Drinking practices blended with those of the conquerors and there is extensive evidence of widespread, heavy alcohol use.

Roman control of Egypt came to an end in the 7th century AD. In 638 AD, Islam arrived in Egypt with its general taboo on alcohol consumption, leading to declining alcohol use after 4,000 years of general, and increasing, consumption.

Commenting on the present-day use of alcohol in Egypt, Dr el-Guebaly says: "The Islamic taboos have worked remarkably well, at least until recently. They seem to be more effective in limiting alcohol consumption than are restrictions on when, and where, alcohol can be sold."

Dr el-Guebaly says that when he was last in Egypt, 10 to 12 years ago, "beer was available everywhere, there were no specific places for selling beer such as the liquor outlets we have in Canada. Despite this, drinking problems were limited. At present though, it looks like the taboos are losing their hold, and the drinking culture is increasing across the Arab countries."

The Egyptian government imposed taxes on alcohol during the era of King Tutankhamen — to curb rising alcohol use.

[1] Here is an example of such warnings from the *Precepts of Ani*:

A warning about the effects of excessive drinking from **The Making of the Scribe Ani**, *a book of etiquette dating back to 1,500 BC.*

INTERNATIONAL

Narcotic pain-killers ease, lengthen lives of terminally ill: MD

By Pat McCarthy

AUCKLAND, NZ — Morphine is a "very good and very safe drug" which "cannot produce addiction, nor can it produce a tolerance," Richard Lamerton, a British specialist in the care of the dying, told a hospice meeting here.

Dr Lamerton says it is a myth that larger doses of narcotics may shorten patients' lives by inhibiting breathing.

In the days before morphine and similar opiate pain-killers were used properly, he says, such large doses sometimes had to be given to relieve pain that breathing was also suppressed — a side-effect that often shortened lives.

But his own experience shows that these drugs, by easing the sense of breathlessness as well as the pain, relieve the distress which can exhaust the dying. Being able to rest, the patients "live longer, if anything."

"Morphine does not produce drowsiness (or if it does, the drowsiness can be handled in other ways). But there is one side-effect of morphine and the other opiate drugs — constipation," he adds.

One of the first British medical practitioners to specialize in the care of the dying, Dr Lamerton is medical director of St Joseph's Hospice in London. A critic of "medical mythology" about pain control in terminal diseases, he published *Care of the Dying** in 1973.

To control severe pain, Dr Lamerton says the strong narcotic analgesics such as morphine, diamorphine, or Physeptone (methadone hydrochloride) might be needed.

"Fearing that the patient might become addicted, doctors are often reluctant to use adequate doses of these drugs. Given by mouth, often mixed with a little gin and cocaine in one of the variations of the so-called 'Brompton cocktail,' these drugs do not have to be given in the ever-increasing doses dreaded by those unaccustomed to their use.

"Of course, if an inadequate dose is given, by injection, so that by the time of the next medicine-round the patient has pain again and is longing for the relief that the injection brings, then the scene is perfectly set for the development of physical and psychological dependence."

To control constant pain in the dying, he says the analgesic must be given regularly, day and night.

"Pain severe enough to require large doses of narcotics is rare. The usual starting dose in one hospice which uses diamorphine is 5mg or 10mg, given by mouth every four hours. This may be increased, to reach double that dose before the patient dies.

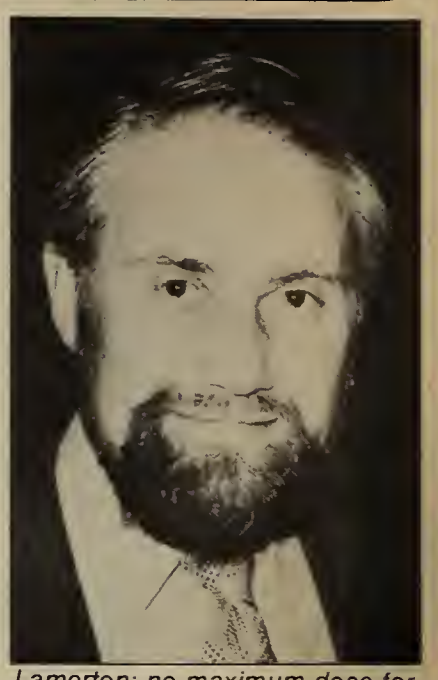
"In one series, only 13% of patients ever needed more than a 30mg dose, which is a small quantity by any standards."

Dr Lamerton says there is "no maximum dose" of an analgesic drug for a dying patient — if the pain really needs five times the normal amount, then that is the correct dose.

When narcotic analgesics are given by injection, instead of by the mouth, the dose should be halved because not all of the drug is absorbed from the gut, he adds.

"In short, by carefully observing the individual's response, the doctor can titrate his drugs against the patient's pain."

Reviewing the doctor's repertoire of drugs and techniques for remedying dying patients' symptoms, Dr Lamerton observes in his book that alcohol "helps almost everything." He describes it as "a first-class sedative and an excellent adjuvant in the relief of pain."



Lamerton: no maximum dose for the dying.

*(*Care of the Dying*, by Richard Lamerton, foreword by Cicely Saunders [The Care and Welfare Library, 1973]. Now also published by Penguin.)

Alcohol policy suppression 'a shameful act'

British alcohol experts lambast government

LONDON — Some of Britain's leading experts in the field of alcohol addiction have published a scathing attack on the government — and it is more outspoken than medical utterances have been for a long time.

It is an editorial in the normally uncontroversial *British Journal of Addiction*, criticizing the government's failure to publish a report on alcohol policy drawn up by its Central Policy Review Staff (known here as the "Think Tank") in 1979.

The report has been awaited by medical professionals since it is rumored to urge immediate government action to stop the steady rise of alcohol consumption in the UK.

Thatcher: no bouquets for curtness.

When Prime Minister Margaret Thatcher was asked in Nov, 1979, in the House of Commons if she would publish the report, she said, simply: "No."

The *British Journal of Addiction* says: "Thus the relevant parliamentary exchange report in Hansard — a matter of manifest health importance disposed of with one curtly-negative word, and reasons for refusal not stated.

"What can these reasons be? If the government's argument is that the Think Tank has in some ways got its facts, perspectives, or conclusions wrong, that is a judgement which we might ourselves be allowed to make or refuse by reading the text, and debate could be no harm.

"It is simply not good enough for the government to hide behind the routine and selective cover story that such a report is intended only as 'confidential advice to ministers.' We have a right to know what ministers are being advised, and whether they are flouting that advice."

The journal argues that if the reason for the report's suppression is "bare-faced, political expedience" it would be a "shameful act" begging the question whether the people can trust the government.

"Perhaps the most important alcoholism statistics the prime minister could furnish us with at Question Time (in the House of Commons) would be on the number of members of parliament who are in some way connected with the liquor trade or the advertising lobby, and the contribution from party funds which come from similar sources."

The editorial goes on to state that the contents of the report are known, but legally unpublishable, and that it reasserts the ever-rising costs of alcohol misuse.

The report argues that the government should take immediate action to prevent any further increase in per capita alcohol consumption; prevent any further relaxation of liquor licensing; scrutinize advertising more carefully, and set up a new advisory council on alcohol policies.

The editorial concludes that to suppress the Think Tank report while selling on bookstalls a Home Office document on alcohol policy (*Alcoholism and Social Policy: Are We On The Right Lines?*) which questions the connection between liquor supply and alcoholism rates, is "even more disquieting.

"The only way to put this situation right is for the government to show courage and publish the Think Tank report forthwith. Public money was spent on the preparation of that report and it should be public property. Continuing suppression must have about it the sick smell of scandal, with the stench worse each month that follows."

The editorial is signed by four consultant psychiatrists; the dean and sub dean of London University's Institute of Psychiatry; a professor and former consultant to the World Health Organization, and four university lecturers in alcoholism studies.

Doctors to brush up on spotting alcoholism

LONDON — The influential British Medical Council on Alcoholism is taking a fresh initiative to warn doctors about the dangers of drink. It will run seminars for family physicians and hospital doctors, and demand better training on addiction problems in medical schools.

The campaign is being organized by the council's director, Dr Hugh Gough-Thomas, who believes the majority of doctors fail to appreciate the true scale of the alcohol threat.

He told **The Journal** this has the effect of causing some physicians to overlook the possibility of a diagnosis of alcoholism, particularly if they are working in busy, urban offices. Sometimes patients complain of depression, indigestion, or anxiety which may mask alcohol problems, and are prescribed drugs which may aggravate the problem.

"There must be a greater awareness that alcohol may lie behind many of the problems for which doctors are consulted," he adds.

Country doc refusing patients who smoke

LONDON — A country doctor who once smoked three packs of cigarettes a day before giving up, now says he will not accept new patients if they smoke.

Hugh Cox, who lives in High Wycombe, outside London, says: "I detest the habit so much, and it is invariably such a mutual waste of time trying to treat smokers, that I have decided to take a stand."

Just as patients have the right to choose a doctor under the National Health Service, the doctor does have the right to choose patients. Dr Cox is turning away prospective patients if they refuse to try and stop smoking.

He adds: "Smokers are likely to contract serious illness up to 14 times more readily than non-smokers. There is absolutely no doubt in my mind that smoking leads to illness, and that people should not put their health at risk in this way."

opiates opiates opi

factsheet

Opiates are found in the juice extracted from the seed pod of the Asian poppy, *Papaver Somniferum*. The drugs derived from this extract include opium and its constituents, codeine and morphine, as well as their derivatives, such as heroin.

The opiates have been used both medically and recreationally for centuries. A tincture of opium called laudanum has been widely used since the 16th century as a remedy for "nerves," or to depress coughing, or stop diarrhea.

By the early 19th century, morphine had been extracted in a pure form suitable for solutions, and with the introduction of the hypodermic needle in the mid-19th century, injection of the solution became the common method of administration.

Heroin (diacetylmorphine) was introduced in 1898, and was heralded as a remedy for morphine addiction. Although heroin proved to be a better painkiller (analgesic) and cough suppressant than morphine, it was also more likely to produce dependence.

Of the 20 alkaloids contained in opium, only codeine and morphine are still in widespread clinical use today. In this century, many synthetic drugs have been developed which have essentially the same effects as the natural opium alkaloids.

Each of the opiate-related synthetic drugs, such as meperidine (Demerol*) and methadone, was developed to provide an analgesic without addicting properties. Unfortunately, however, all the opiates and their synthetic derivatives which are effective as analgesics are also addictive.

APPEARANCE

Opium appears as either dark brown chunks or in powder form. It is generally eaten or smoked. Heroin usually appears as a white or brownish powder which is dissolved in water for injection. Most street preparations of heroin contain only a small percentage of the drug, and are diluted with sugar, quinine, or other substances. Other narcotic analgesics are obtainable in a variety of forms such as capsules, tablets, syrups, elixirs, solutions, and suppositories. Usually opiate solutions are injected under the skin ("skin popping") or directly into a vein or muscle, but they may also be sniffed or administered either orally or rectally.

EFFECTS

The effects of any drug depend on the amount taken at one time, the past drug experience of the user, the circumstances in which the drug is taken (the place, the feelings and activities of the user, the presence of other people, the simultaneous use of alcohol or other drugs, etc), and the manner in which the drug is taken.

Short-term effects are those which appear rapidly after a single dose and disappear within a few hours or days. Opiates briefly stimulate the higher centres of the brain, then depress activity of the central nervous system. Immediately after opiate injection into a vein, the user feels a surge of pleasure or a "rush" which gives way to a state of gratification into which hunger, pain, and sexual urges usually do not intrude. The dose required to produce this effect may initially cause restlessness, nausea, and vomiting.

With moderately high doses, the body feels warm, the extremities heavy, and the mouth dry. Soon, the user goes "on the nod," an alternately wakeful and drowsy state during which the world is forgotten.

As the dose is increased, breathing becomes progressively more depressed. With very large doses, the person cannot be roused, the pupils are contracted to pinpoints, the skin is cold, moist, and bluish, and profound respiratory depression resulting in death may occur. This is a particular risk on the street where the contents of a "hit" cannot be accurately gauged.

In a therapeutic setting, the effects of a usual dose of morphine lasts approximately three to four hours. Although pain may still be perceived during this time, the reaction to it is reduced, and a state of contentment achieved. This follows from the sensation of emotional detachment induced by the drug.

Long-term effects are those which appear following repeated use over a long period of time. Chronic opiate users may develop endocarditis, an infection of the heart lining and valves by organisms introduced into the body during injection of the drug. Abscesses, cellulitis, liver disease, and possibly brain damage may also result from infections associated with unsterile injection techniques. Tetanus is common among users with a long history of subcutaneous injection. Pulmonary complications, including various types of pneumonia, may also occur due to lifestyle and the effects of narcotics on respiration.

OPIATES AND PREGNANCY

Research has shown that an estimated half of all opiate-dependent women experience complications during pregnancy and childbirth. Anemia, cardiac disease, diabetes mellitus, pneumonia, and hepatitis are among the most common medical problems. These women also demonstrate an abnormally high rate of spontaneous abortion, breech delivery, cesarian section, and premature birth. Opiate withdrawal has also been linked to high incidence of stillbirths. Infants born to opiate-addicted mothers are smaller than average and frequently show evidence of acute infection. The majority exhibit withdrawal symptoms of varying degrees and duration. The mortality rate among these babies is also higher.

TOLERANCE AND DEPENDENCE

Regular use of opiates induces tolerance, making increased doses necessary to produce the same effects.

Chronic users may also become psychologically and physically dependent on opiates. Psychological dependence exists when a drug is so central to a person's thoughts, emotions, and activities that it is extremely difficult to stop using it. This condition is marked by a compelling need or craving to keep taking the drug. Physical dependence is a state wherein the body has adapted to the presence of the drug and withdrawal symptoms occur if its use is stopped abruptly. Occasional heroin users, sometimes referred to as "chippers," report intermittent use without developing physical dependence. Withdrawal from opiates, which may occur as early as a few hours after the last administration, produces uneasiness, yawning, tears, diarrhea, abdominal cramps, goosebumps, and a runny nose. These symptoms are accompanied by a craving for the drug. The most marked withdrawal indicators peak between 48 and 72 hours after the last dose and subside over a week. Some bodily functions do not return to normal levels for as long as six months. Sudden withdrawal by heavily dependent users who are in poor health has occasionally been fatal. However, opiate withdrawal is much less dangerous to life than the alcohol and barbiturates' withdrawal syndromes are.

WHO USES OPIATES

A small proportion of those for whom opiates have been prescribed in medical treatment become dependent. Even codeine use continued inappropriately may get out of control. In such cases, medical advice should be sought since withdrawal symptoms may result from abrupt cessation after physical dependence has been established. People who become dependent as a result of medical treatment are refered to as "medical addicts." The "professional addict" is someone in the medical or allied professions for whom the availability of these drugs is high. The largest proportion of opiate abuse falls, however, into the street use category.

During the last few years, synthetic narcotics such as hydrocodone, hydromorphone, oxycodone, and meperidine have gained prominence as drugs of dependence. Physicians are sometimes pressured to provide prescriptions for these medications. They are also stolen from pharmacies, sold on the street, and used illegally. Today, abuse of other narcotic-based medicines such as Percodan,* Dilaudid,* and Novahistex DH* is common.

THERAPEUTIC USES

Opiates and their synthetic counterparts, which are legally and pharmacologically classed as narcotics, are used in modern medicine to relieve the acute pain suffered as a result of disease, surgery, or injury, in the later stages of such terminal illnesses as cancer, in the treatment of some forms of acute heart failure, and in the control of moderate-to-severe cough and diarrhea.

OPIATES AND THE LAW

The federal Narcotic Control Act regulates the possession and trafficking of all opiates. The act permits individual physicians, dentists, pharmacists, and veterinarians, as well as hospitals, to keep supplies of opiates. The public must obtain these drugs from such authorized sources.

Unlawful possession of opiates, including cultivation of the opium poppy, may result in a maximum prison sentence of seven years. The maximum penalty for trafficking or possessing opiates for the purpose of trafficking is life imprisonment. Importing or exporting opiates without authorization also carries a maximum penalty of life in prison.

The Opiates factsheet is also available in pamphlet form at 5¢ per copy (prepaid), from the Addiction Research Foundation. For information, write Marketing Services, dept 257, Addiction Research Foundation, 33 Russell Street, Toronto, Canada M5S 2S1, or telephone (416) 595-6056

The Journal

NEWS

NB see big gains for provincial EAPs in last three years

By John Carroll

MONCTON — In three years employee assistance programs (EAPs) have increased their coverage from less than 1% of New Brunswick's occupational community to 11%. And it's estimated that within a year the total will double.

The increase is the result of efforts by the EAP division of the New Brunswick Alcohol and Drug Dependency Commission (ADDC). The division is under the guidance of provincial director of EAP, Wayne Weagle.

In operation since early 1979, and with a staff now of four, the division has increased EAP participation from 1,500 employees in the pre-division days to a current 30 companies and unions which have officially adopted EAP policies, and had supervisors and shop stewards undergo training. Thus 27,000 or 11% of the 234,000 employed workers in the province have access to EAP counselling.

Mr Weagle told **The Journal** that a further 32 companies and organizations are working with the division, in stages ranging from preliminary, promotional meetings through to the end-game of writing official operational EAP policies.

He estimates that if most of these contacts develop into actual programs, another 26,000 members of the occupational community will be covered.

Mr Weagle says what is noticeable is the acceleration in pace, and the change of outlook, with respect to EAP. Initially, the division had to do it's own missionary work by going to companies and unions. But the pace has picked up so that as much progress is anticipated in the next year as has been achieved in the past three years.

"Now the companies and unions are coming to the ADDC, rather than us going to them," says Mr Weagle, adding that the division wants 30% to 35% of the occupational community to participate by 1984.

The rapid development of EAPs has had what he terms "a good, a significant impact on our treatment centres." Both in-patient and out-patient referrals by companies with EAPs had impressed treatment centre staff, he says.

"These people tend to be quite highly motivated and respond more readily to treatment. The staff are impressed by this motivation and by the rehabilitation rate. The North American average of a recovery rate of 70% to 80% is being consistently met."

The acceptance of the division's mission has resulted in the staff "working flat out," says Mr Weagle. He has under his direction three staff consultants, one in each of Moncton, Fredericton, and Saint John. The division operates on a budget of approximately $100,000.

Mr Weagle hopes to see early development of assessment and referral services throughout the province. The EAP concept is broadly-based, and such services could assist in determining, accurately, the problem from which a worker may be suffering, and ensuring channelling to the correct treatment.

In the long-run, he hopes financing for these centres will come from business and labor, although in the near-term, federal funding may be sought.

Weagle: companies are coming to us.

Mr Weagle says EAP division priorities are:

- Proliferation of EAPs throughout the NB occupational community;
- Establishment of refresher courses for firms with EAP policies in place. These would involve courses designed to identify strengths and weaknesses of existing programs and to meet, more adequately, future needs;
- Development of a Program Planning Resource Guide for joint management-union — EAP committees, to maintain momentum, keep interest and exposure at high initial levels, and counter the waning of interest that often sets in several months after a program has been established;
- Continuing support for the newly-formed NB Association of Employee Assistance Programs, a voluntary group of labor and management representatives from about 25 companies, whose purpose is to share ideas, upgrade understanding, and promote a common interest in EAPs.

Book's heroine 'Dinky Hooker,' a hit with kids

DEARBORN, MI — *Dinky Hooker Shoots Smack*, **one of the titles in a federally-subsidized book give-away program, is a hit in grades five and six at McDonald's School here.**

Kids today won't read *Tom Sawyer* **and** *Treasure Island*, **says one parent who helped organize the book program. "They want to read about something relevant to them, like TV or disco skating. The classics don't sell."**

Dinky Hooker **is the heroine in a story about a drug rehabilitation program.**

The Journal

Marketing Dept (595-6056)
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Advertising Rates

a) Regular Line Rates	$1.09 line
b) Standard Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
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Circulation: 15,094

(Ontario, 11,580, other provinces, 815, USA, 1,979, foreign, 720) Bulk, 3,700, Media, 1,273

Single Subscription Rates
Ontario Residents free
Other Canadian Residents $12 per year
U.S.A. & Foreign Residents $16 per year

Bulk Subscription Rates
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Member of CCAB

ISSN 0044-6203 Printed in Canada

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Susan Reid, the coordinator of the group, at (416) 595-6150.

The Last To Know

Number: 501.

Subject Heading: Women and alcohol; drugs and women; attitudes.

Details: 55 mins; 16mm/3/4'' video-cassette; color.

Synopsis: This film focuses on the ''special'' problems of women's health in terms of alcohol and drug abuse. Four women whose lives have been affected by alcohol, prescription drugs, and/or street drugs, are interviewed throughout the film. Their intimate accounts of the factors contributing to their problems reveal how physicians, the media, and society in general, view the woman alcoholic. Film inserts of lifestyle advertising related to alcohol and drugs exemplify these issues, while interviews with ''the man on the street'' suggest that there is a gross misunderstanding on the part of society regarding this problem.

General Evaluation: Good to very well-produced film was highly rated both in its emotional impact, and in both in its emotional impact and in its ability to produce attitudes opposed to drug abuse. The group said it would be an effective teaching aid with its realistic portrayal of the current situation. The information provided would help in decision-making regarding alcohol and drug use by women.

Recommended Use: The film seems to be intended for adults and drug users but was judged to be beneficial to all audiences aged 15 and older, including health professionals. Although the presence of a resource person is not essential, it would be useful to have someone lead a discussion after the film.

Alcohol and Drugs: How They Affect the Body

Number: 492.

Subject Heading: Youth and alcohol; drugs and youth; attitudes.

Details: 26 min; 16 mm; color.

Synopsis: This film, hosted by Mel Sharp, explores various aspects of pollution (air and water pollution, and pollution of one's body), through an interactive exchange with elementary-school children. Interviews with young teenagers who have become drinkers or drug users highlight the problems and consequences of their dependence. Mr Sharp asks the children to suggest a number of ways a person could ''get off'' drinking and other drugs, and concludes that since ''we are learning ways how not to pollute our environment, we should learn how to look after our (body's) own environment.''

General Evaluation: Fair (2.5). The film was judged to be boring, unrealistic, and poorly-produced, due to the irrevelant and confusing nature of the information presented. Despite the contemporary nature of this film, the film was judged to be an ineffective teaching aid. If used, there should be a resource person present to rectify factual discrepancies and facilitate discussion.

Recommended Use: This film is unlikely to benefit its intended audience of elementary-school children (age eight to 11 years) or other audiences.

Living With Stress

Number: 498.

Subject Heading: Lifestyle; treatment; attitudes.

Details: 14 min; 16 mm; color.

Synopsis: Stress is defined as the way a person's body reacts to ''stressors'' — anything that produces changes and alters the way a person feels or acts. The film emphasizes that differences exist between people in how they react to stress, and indicates that there are both ''good'' and ''bad'' ways to respond. ''Bad ways'' of relieving stress — drinking, smoking, and overeating — provide temporary relief, but may lead to long-term, deleterious effects. ''Good ways'' of managing stress are suggested through a series of interviews with people who have overcome problems with stress. Such techniques include hobbies, talking about stress with friends, exercising, becoming involved in relaxation exercises either alone or with others, and using biofeedback.

General Evaluation: Very good (4.8). This contemporary, well-produced film was judged to be a good teaching aid, informative, and presenting a clear message. The length of the film is appropriate to most educational settings and is likely to help people decide on alternatives for managing stress. The group recommended the film be broadcast.

Recommended Use: The film is intended for adult audiences, drug users, and health professionals, and was judged to be beneficial to all people aged 15 and older.

DEPARTMENT

New Books

by RON HALL

Training Guidelines and Workbook for the Behavioral Management of Intoxicated and Disruptive Clients

. . . by Ann E. Cox

This manual has been designed to provide instructors with useful information to plan and conduct a training program, and to provide the text of the course together with steps and exercises for conducting the training sessions. A short bibliography is appended to provide more background information. The purpose of this training is to improve staff skills in managing situations involving disruptive clients. The objectives of the course are to train participants to reduce the number and length of incidents associated with intoxicated clients, which disrupt service and client care; and to reduce the amount of staff time spent in dealing with those disruptive incidents. The manual is divided into two sections. Training Guidelines deals with pre-course planning considerations which are effective in conducting this type of training. The workbook contains case material for participants, suggestions for instructors, and a lesson plan for presenting the material.

(Addiction Reseach Foundation, Marketing Services, 33 Russell Street, Toronto, Ontario M5S 2S1, 1981. 62p, $7.95. ISBN: 0-88868-055-4)

Unterrichtswerk zu Drogenproblemen: Unterrichtswerk für die Sekundarstufe I (5. bis 10. Schuljahr) [Textbook on Drug Problems for Grades 5 to 10]

. . . by K.A. Noack, K. Kollehn, U. Richter, N. Weber, et al.

Using an interdisciplinary approach encompassing biology, chemistry, sociology, art, and language, this textbook, published in German by the German federal office for Health Education, provides information on the medical, psychological, social, legal, and economic aspects of drug use. It primarily addresses the teacher and includes detailed lesson plans developed and tested by secondary school teachers in collaboration with education specialists from the Paedagogischen Hochschule in West Berlin. Recommendations for working with parents, handout sheet originals, and transparencies are also provided. This textbook is presented in binder form with colored index tabs for the general areas: introduction; drug use and dependence in our society; drugs and the law; textbook aims, and for the four areas of concern: street drugs; prescription drug abuse; alcohol; smoking. It was written in consultation with pertinent experts and is intended as a reliable source book from which appropriate class material can be selected for developing or strengthening a healthy attitude towards drugs. (Book Report prepared by Beatrice Boucher.)

(Ernst Klett Verlag Stuttgart, Abtlg. Information und Beratung Expeditionslager, Postfach 1170, 7054 Korb, W. Germany, 1980. 472 p. DM 48.50)

Problems of Drug Dependence 1980

. . . edited by Louis S. Harris

The papers in this monograph were presented or read at the 42nd Annual Scientific Meeting of the Committee on Problems of Drug Dependence, in Hyannis, Massachusetts, in June, 1980. Topics presented include the effects of drugs on the central nervous system, their pharmacological action, biological disposition, safety, abuse potential, and clinical usefulness. Annual progress reports of the NIDA — supported dependence studies of new compounds are included, in addition to the 40 papers presented and six papers read by title. This volume is number 34 in the National Institute on Drug Abuse Research Monograph series.

(US Government Printing Office, Washington, DC 20402, 1981. 441p. $7. S/N 017-024-01061-8)

The Non-Drinker's Drink Book: A Guide to Mixing Non-Alcoholic Drinks

. . . by Gail Schioler

There are 140 quick-and-easy recipes in this book for anyone to mix and serve for all occasions. Created to take little time to prepare, the ingredients are easy to substitute or have their proportions changed to suit individual tastes. The book was written by the wife of a diplomat who attended many cocktail parties and realized he could easily succumb to the diplomat's occupational hazard and become an alcoholic.

(Personal Library, available from Addiction Research Foundation, Marketing Services, 33 Russell Street, Toronto, Ontario M5S 2S1, 1981. 159p. $10.95. ISBN 0-920510-16-7)

Goodbye, Blues: Breaking the Tranquilizer Habit the Natural Way

. . . by Bernard Green

The basic premise of this book is that tranquillizers, sleeping pills, and antidepressant sedatives are not necessary to handle the stress of everyday life. For many people, after periods of prolonged use, they become stress factors. Case histories are used to demonstrate the variety of problems and circumstances which can cause the need for such drugs. Information is provided on how to cope with stress without resorting to the additional stress of medication — by combining vitamin therapy, exercise, and a practical form of meditation easily learned and incorporated into the daily routine.

(McGraw-Hill Book Company, 35th Floor, 1221 Avenue of the Americas, New York, NY 10020. 1981. 173p. $10.95. ISBN 0-07-024337-9)

Other Books

Forensic Toxicology: Controlled Substances and Dangerous Drugs — Lowry, W. T. and Garriott, James C., Plenum, New York, 1979. List of controlled and non-controlled commonly-abused substances; pharmaceutical dosage forms; classification of scheduled substances; regulation of controlled substances; excepted and excluded substances; drug isomers and derivatives; analysis. References, index. 445p. $37.50.

Marijuana Research Findings: *1980* — Petersen, Robert C. (ed). National Institute on Drug Abuse, Rockville, 1980 (NIDA Research Monograph Series 31). Reviews with references on marijuana and health; human effects; chemistry and metabolism; effects on memory and cognition; neuroendocrine function, reproduction, and development; effects in combination with ethanol and other drugs; therapeutic aspects. 225p.

Assessing The Impact On Public Health, Individual Deficit, And Organ System Damage Associated With Psychoactive Substance Use — Schuster, C. R., Berlman, J., and Hartel, C. R., National Institute on Drug Abuse, Rockville, 1980. Prepared for NIDA's International Activities program to provide a substantive review of five drugs (stimulants and benzodiazepines); to be used by the WHO Evidence, Geneva, Sept 1980. References 117p.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

The Canadian Addictions Foundation first Atlantic Regional Symposium on Youth and Addictions — May 4-7, Saint John, New Brunswick. Information: J. E. MacIntyre, Ridgewood Treatment and Rehab Centre, Postal Station "B," PO Box 3566, Saint John W, NB E2M 4Y1.

"The Chemical Crisis — Can We Cope?" A Community Conference, Alcohol and Drug Concerns — May 13, Waterloo, Ontario. Information: Alcohol and Drug Concerns Inc, 15 Gervais Drive, Suite 603, Don Mills, ON M3C 1Y8. (416-449-4933).

Alcoholism and Your Patient — May 13, Toronto, Ontario. Information: Linda Bell, The Donwood Institute, 175 Brentcliffe Road, Toronto, ON M4G 3Z1.

Cognitive Behavior Therapy — May 14, Toronto, Ontario. Information: Ms E. Essue, Clarke Institute of Psychiatry, 250 College Street, Toronto, ON M5T 1R8.

Mental Health Information Systems: Problems and Prospects — May 14-15, Toronto, Ontario. Information: Hincks Lectures, Ontario Mental Health Foundation, Suite 1708, 365 Bloor Street E, Toronto, ON M4W 3L4.

135th Annual Meeting of the American Psychiatric Association — May 15-21, Toronto, Ontario. Information: American Psychiatric Association, 1700 18th Street NW, Washington, DC 20009.

Child Abuse/Child Neglect, Sexual Abuse/Incest Workshop — May 26-28, London, Ontario. Information: Ranford-Gascoyne Associates, PO Box 1756, Windsor, ON N9A 6Y1.

1982 Western Canadian Alcoholism Conference — May 26-28, Regina, Saskatchewan. Information: Conference Chairman, 2839 Victoria Avenue, Regina, SK S4T 1K6.

Ethnocultural Issues in Phychotherapy — June 12, Toronto, Ontario. Information: Ms E. Essue, Conference Secretary, Clarke Institute of Psychiatry, 250 College Street, Toronto, ON M5T 1R8.

Summer School on Addictions — June 20-25, Charlottetown, Prince Edward Island. Information: The Department of Extensions and Summer Sessions, University of Prince Edward Island, Charlottetown, PE1 C1A 4P3.

73rd Annual Conference Canadian Public Health Association — June 21-24, Yellowknife, Northwest Territories. Information: Gerald H. Dafoe, Executive Director, Canadian Public Health Association, 1335 Carling Avenue, Suite 210, Ottawa, ON K1Z 8N8.

The Northern Symposium on Addictions — June 26-30, Yellowknife, Northwest Territories. Information: Canadian Addictions Foundation, 251 Laurier West, Suite 1100, Ottawa, Ontario K1P 5R6.

23rd Institute on Addiction Studies — July 18-23, Hamilton, Ontario. Information: Karl N. Burden, Course Director, Alcohol and Drug Concerns, 15 Gervais Drive, Suite 603, Don Mills, ON M3C 1Y8.

Summer Course in Addictions — July 19-23, Toronto, Ontario. Information: School for Addiction Studies, 8 May Street, Toronto, ON M4W 2Y1.

United States

Family Program For Professionals — Offered once each month, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Cocaine Today — May 13-14, Santa Monica, California. Information: The American Council on Marijuana and Other Psychoactive Drugs, 6193 Executive Blvd, Rockville, Maryland 20852.

Adolescents, Alcohol, and Drug Abuse — May 14, Milwaukee, Wisconsin. Information: Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S 13th Street, Milwaukee, WI 53221.

Drug Abuse Prevention for Parents and Professionals — May 16-19, Charlotte, North Carolina. Information: Charlotte Drug Education Center, 1416 E Morehead Street, Charlotte, NC 28204.

Chemical Dependency and Family Recovery Workshop — May 16-21, Minneapolis, Minnesota. Information: Betty Reynolds, Johnson Institute, 10700 Olson Memorial Highway, Minneapolis, MN 55441-6199.

Nursing Series — Pharmacology, Detoxification and Withdrawal: Basic Skills, Counseling Skills for the Nurse — May 17-21, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Toxicology of the Immune System — May 20-21, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Health Sciences Communications Association 24th Annual Meeting — May 22-26, San Antonio, Texas. Information: Program Committee, HeSCA del Rio, Robert M. Brecht, Biomedical Communications, 328 Gail Borden D-11, University of Texas Medical Branch, Galveston, TX 77550.

Third Annual Illinois Institute on Drug Abuse — May 24-27, Peoria, Illinois. Information: IDDC, 300 N State Street, Chicago, IL 60610.

Alcohol/Drug Counseling Skills II — May 24-28, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

National Conference on Alcoholism and the Family — May 27-30, Valley Forge, Pennsylvania. Information: National Conference on Alcoholism and The Family, Box 277, Wernersville, PA 19656.

Fundamentals of Biochemistry and Genetic Engineering — June 2-4, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Issues, Insights and Concepts — Current Trends and Research in the Field of Alcoholism — June 2-5, River Forest, Illinois. Information: Central States Institute of Addiction, Continuing Education Program on Addiction, 120 West Huron Street, Chicago, IL 60610.

Issues of Sexuality in Alcoholism/Drug Abuse Counseling — June 3-4, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Annual Conference of the Association of Halfway House Alcoholism Programs — June 6-11, Anchorage, Alaska. Information: AHHAP, 786 E 7th St, St Paul, Minnesota 55106.

3rd Annual National Conference on Employee Assistance Programming — June 7-10, Kansas City, Kansas. Information: EAP Conference Center, Bethany Medical Center, 51 N 12th St, Kansas City, KS 66102.

Counseling the Family of the Chemically Dependent — June 7-10, Moorehead, Minnesota. Information: Debby Thornton, C. D. School Secretary, Department of Social Work, Moorhead State University, Moorhead, MN 56560.

National Symposium on Alcohol and Drug Studies — June 7-11, Springfield, Missouri. Information: Rosa Archibald, Burrell Community Mental Health Center, Inc, PO Box 1611 SSS, Springfield, MO 65805.

Assessment and Diagnosis For Chemical Dependency — June 8, Center City, Minnesota. Information: Continuing Education Department, Box 11, Center City, MN 55012.

Substance Abuse: Tools For Action — June 8-11, Byfield, Massachusetts. Information: Helen W. Packard, North Conway Institute, 14 Beacon Street, Boston, MA 02108.

4th Annual Summer Institute: Family Recovery — June 10-12, Milwaukee, Wisconsin. Information: Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Workshop on Chemical Dependency and Adolescents — June 13-18, Minneapolis, Minnesota. Information: Mary Simonson, Johnson Institute, 10700 Olson Memorial Highway, Minneapolis, MN 55441-6199.

University of Utah School on Alcoholism and Other Drug Dependencies — June 20-25, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies — PO Box 2604, Salt Lake City, UT 84110.

The Mid-South Summer School on Alcohol and Drug Problems — Prevention and Treatment — June 20-25, Fayetteville, Arkansas. Information: Gwen Briscoe, GSSW-UALR, Little Rock, AR. 72204.

Basic Workshop on Chemical Dependency and the Family — June 21-25, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Memorial Highway, Minneapolis, MN 55441-6199.

33rd Annual Symposium on Alcoholism — June 21-July 2, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, 12th and E Columbia, Seattle, WA 98122.

Alcohol Studies Program — June 21-Aug 13, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, 12th and E Columbia, Seattle WA 98122.

Sexuality for Alcoholism Counselors — June 22-July 13, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, 12th and E Columbia, Seattle, WA 98122.

Coping In The Eighties — An Institute for Educators on Drug and Alcohol Abuse, Sexuality, Communication and Counseling Skills — June 28-30, Kingston, Pennsylvania. Information: Charles Lull, Dean of Students, Wyoming Seminary, College Preparatory School, Kingston, PA 18704.

6th National Youth Workers Conference — July 5-8, Washington, DC. Information: National Youth Work Alliance, 1346 Connecticut Ave NW, Washington, DC 20036.

11th Annual San Diego Summer Alcohol and Drug Studies Program — July 11-16, San Diego, California. Information: Elizabeth Hendrickson, UCSD Extension, X-001, La Jolla, CA 92093.

Annual Meeting of International Doctors in Alcoholics Anonymous — July 29-August 1, Des Plaines, Illinois. Information: Lewis K. Reed, MD, Information Secretary, IDAA, 1950 Volney Road, Youngstown, Ohio 44311.

7th Annual New Jersey Summer School of Alcohol and Drug Abuse Studies — Aug 1-6, New Brunswick, New Jersey. Information: Ronald L. Lester, Director, New Jersey Summer School of Alcohol and Drug Abuse Studies, Rutgers University, Smithers Hall, New Brunswick, NJ 08903.

Alcohol and Drug Problems Association Annual Meeting — Aug 29-Sept 1, Washington, DC. Information: Alcohol and Drug Problems Association, 1101 15th St, #204, Washington, DC 20005.

6th Annual Summer Institute of Drug Dependence — Aug 29-Sept 3, Colorado Springs, Colorado. Information: The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Evaluating Alcohol and Drug Problems: Current Methods and Findings — Sept 13-17, Brooklyn Park, Minnesota. Information: Leslie Nyberg, Evaluation and Research Department, Box 11, Center City, MN 55012.

The Benzodiazepines Today: Two Decades of Research and Clinical Experience — Oct 9-10, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton Street, San Francisco, CA 94117.

Women In Crisis Inc, Fourth Annual Conference — Nov 10-13, New York, New York. Information: Women In Crisis Inc, 37 Union Square West, New York, NY 10001.

Abroad

10th International Conference of Social Gerontology — May 26-28, Deauville, France. Information: ICSG, 91, rue Jouffroy, 75017 Paris, France.

First Nordic Congress on Traffic Medicine — June 8-11, Linköping, Sweden. Information: Leif Bohlin, Congress Director, Linköping University, S-581 83 Linköping, Sweden.

13th Collegium Internationale Neuro - Psychopharmacologicum Congress — June 20-25, Jerusalem, Israel. Information: Secretariat, 13th CINP Congress, POB 29784, Tel Aviv, Israel.

28th International Institute on the Prevention and Treatment of Alcoholism — July 4-10, Munich, Germany. Information: Wagons-Lits Tourisme, Case postale 1003, 1001 Lausanne, Switzerland.

Working With Problem Drinkers In The Family — July 5-7, Manchester, England. Information: Jane Stott, Course Coordinator, Alcohol Education Centre, 99 Denmark Hill, The Maudsley Hospital, London, England SE5 8AZ.

28th International Institute on the Prevention and Treatment of Alcoholism — July 5-9, Munich, Fed Rep of Germany. Information: International Council on Alcohol and Addictions, Case postale 140, 1001, Lausanne, Switzerland.

1st Congress of the International Society for Biomedical Research on Alcoholism — July 6-10, Munich, Fed Rep of Germany. Information: Ronald G. Thurman, dept of Pharmacology, School of Medicine, 1124 Faculty Laboratory Office Building, University of North Carolina at Chapel Hill, NC 27514.

Second Biennial AU School of Justice Institute on Juvenile Justice — July 11-30, London, England. Information: Dean Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

1982 Summer School on Alcohol Problems — Aug 14-20, York, England. Information: Jane Stott, Course Coordinator, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London SE5 8AZ.

11th International Conference on Health Education — Aug 15-20, Hobart, Tasmania, Australia. Information: Joy Faldt, Australia Society of Health Educators, PO Box 818, Fortitude Valley, Queensland, Australia 4006.

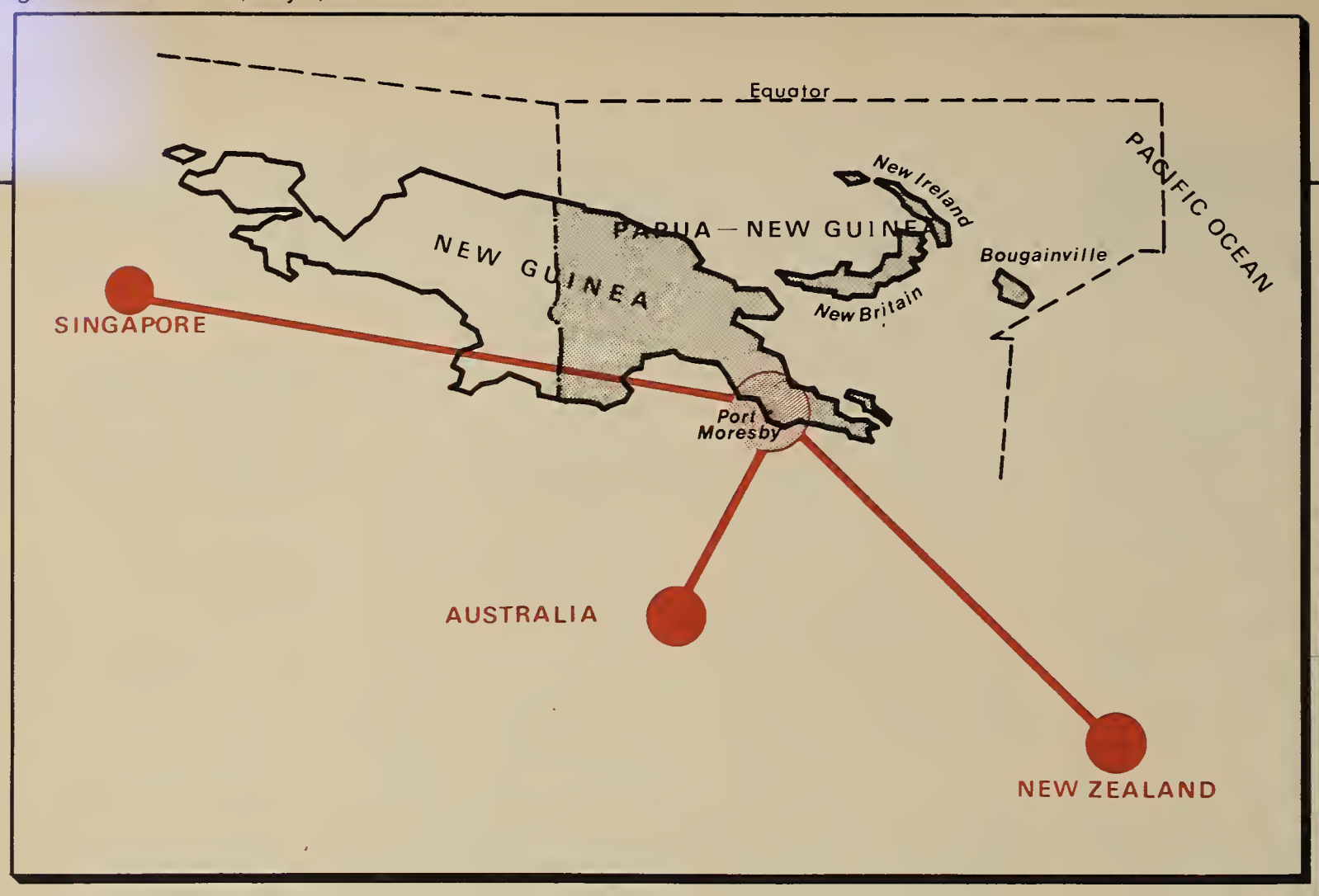
Working With Problem Drinkers — Aug 23-27, York, England. Information: Jane Stott, Course Coordinator, Alcohol Education Centre, 99 Denmark Hill, The Maudsley Hospital, London SE5 8AZ.

Fourth World Congress for the Prevention of Alcohol Problems, Alcoholism and Drug Dependency — Aug 29-Sept 2, 1982, Nairobi, Kenya. Information: ICPA — International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St NW, Washington, DC 20012.

33rd International Congress on Alcoholism and Drug Dependence — Oct 9-15, Tangier, Morocco. Information: Archer Tongue, ICAA, Case postale 140, 1001 Lausanne, Switzerland.

Influence of Environment on Man — Nov 17-20, Vienna, Austria. Information: Secretariat Brussels, rue E Bouillot 61, Box 11, B-1060 Brussels, Belgium.

NSAD 10th Biennial Summer School on Alcohol, Drugs and Chemical Dependency — Jan 26-28, 1983, Wellington, New Zealand. Information: Bursar, Barbara Mills, NSAD, PO Box 1642, Wellington, NZ.



Papua New Guinea research highlights anthropological role in alcoholism field

By Harvey McConnell

WASHINGTON — Anthropologists are much better placed than "hit and run" consultants from abroad, social scientists, or health workers to advise Third World countries about alcohol problems and policies.

Most anthropologists have spent a minimum of a year and usually it is much longer, among various groups, and — if they are asked — can make a "rich and positive contribution" to alcohol policy, argues Mac Marshall, PhD, himself an anthropologist at the University of Iowa, Iowa City.

Dr Marshall has a wide knowledge of cultures in the Pacific, and recently (1980 - 1981) was project director for a national study on alcohol problems for the young government of Papua New Guinea.

He told the annual conference of the National Council on Alcoholism here "it has been said that drinking problems are putting the Third World on the map. Recent evidence seems to bear that out."

Despite the knowledge a problem is growing, information on use and abuse of alcohol in the Third World is spotty.

Dr Marshall: "Such data as does exist is fragmentary and impressionistic, and gathered by anti-alcohol crusaders — what I call 'hit and run' consultants sponsored by international organizations; social scientists with a rather narrow view, such as economists; or by health workers, who often have an equally-limited perspective on the subject.

"Anthropologists are conspicuous by their absence from studies designed to form government policy toward preventive health and social control aspects of alcohol in The Third World.

"This absence is ironic because anthropologists frequently are among those with the greatest knowledge of Third World societies."

This absence is also regrettable because the approach of contemporary anthropology, with its emphasis on the individual, society, and the cultural system, offers a valuable addition to the limited and superficial data on alcohol which exists at the present time for most Third World countries.

Dr Marshall is a happy exception to the general rule — he, as an anthropologist, was picked by the government of Papua New Guinea to gather information on alcohol use. Papua New Guinea, with its capital at Port Moresby, became independent from Australia in 1975. Much of the country experienced fierce fighting during World War II.

He notes that while there is a "large and rich literature" on alcohol and alcohol problems in many areas of the world, the literature on alcohol and culture in the Pacific islands continues to be "woefully inadequate."

And even those studies which have been made in the Pacific have largely ignored Papua New Guinea, where prohibition against native drinking was rigidly enforced by the Australians until independence.

Dr Marshall says that study on alcohol and culture has grown rapidly in the past two decades "and this has added an important dimension to our understanding of the varying ways alcoholic beverages are made and consumed, and of the diverse expectations people have of how others will behave once alcohol has been drunk."

It is taken for granted that social and cultural facets are as important as physiological and psychological ones.

Papua New Guinea is the largest country in Oceania, and perhaps the most culturally diverse country in the world. Although it has a population of about three million, 700 different languages are spoken, some 25% of the world's languages.

Dr Marshall says when he initiated his study he drew on research by scholars in the country, particularly those who lived in the Highlands, or mountainous areas.

"Papua New Guinea has seen a lot of anthropological research in the last 25 years, but relatively little has been directed to public-policy questions. Most anthropologists gather data on alcohol consumption but they do need a special incentive to put this information in their reports."

In order to spark this interest among his peers, Dr Marshall decided to hold an international conference, and anthropologists were encouraged to attend and present reports.

Port Moresby: beer is a luxury item and symbol of participation.

Since prohibition was lifted in the country in 1962, beer has become the status luxury item with two breweries producing for the country. During the past 10 years, beer distribution has expanded into the highlands.

"The reason beer is such a status item is that the 'Aussie' rulers were heavy drinkers. Beer is certainly a high-status, luxury commodity and rivals pork in some parts of the highlands. A carton of beer is now referred to as 'small pig.' "

Most heavy and regular alcohol consumption until now has been in towns, because access to rural areas is so limited.

The practice of the Papua New Guineans is to drink to get drunk. They will drink until all the alcohol is consumed, and men drink more, and more frequently, than women.

Beer has been incorporated into the traditional pattern of exchange.

Dr Marshall: "Rural villagers are willing to invest substantial sums in beer as Melanesian exchanges have a built-in growth factor: a reciprocal gift must always exceed that which precipitated it.

Harvesting tea.

"While this can be viewed as a waste of economic resources by the amount of money spent on beer, it must be recognized, at the same time, that investments in the traditional exchange network remains the most secure, and hence rational, that most rural people can make.

"In addition, many view beer buying as a symbol of their participation in a modern, developing economy."

At the moment, the emphasis is on drinking in the towns, and probably this is where education efforts should first be focused, says Dr Marshall.

One fascinating aspect of the situation is that "in some parts of the country, alcohol has not yet been introduced, but the people have a whole set of conceptions about what happens to you when you drink."

Although the government is worried enough by social and economic ramifications that might happen in the future from alcohol use, the problem is not yet mammoth: Port Moresby has an AA (Alcoholics Anonymous) chapter with some 13 members, 11 of these members are foreigners.

One treatment facility has been set up by the government as a sort of detoxification centre, and Dr Marshall said that about a dozen people had been through it by the time he left at the end of 1981.

However, dealing with illness caused by alcohol is low down the priority list when just coping with infectious disease and treating malaria victims, for example, nearly swamps the health system.

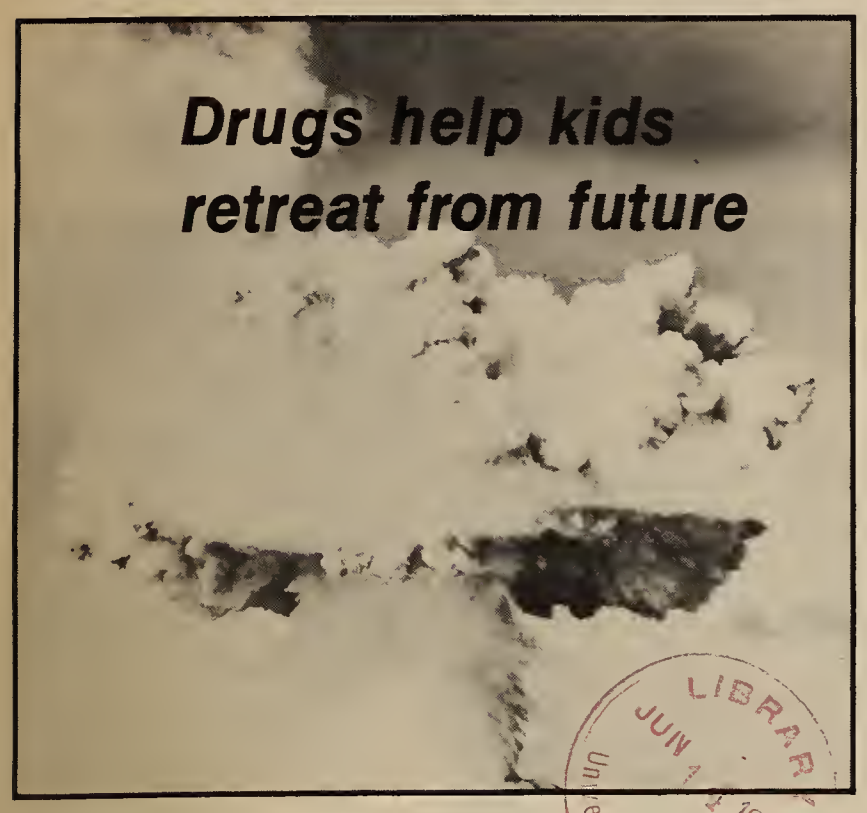
Dr Marshall said his own experiences as an anthropologist, and his observations in Papua New Guinea at what fellow anthropologists can contribute to the alcohol use, abuse, and policy questions, indicate what a valuable contribution they can make.

"The understanding the anthropologists achieve in their long-term studies are the exact opposite of the fragmentary and impressionistic ones which Third World policy makers chiefly have at their disposal.

"The very rich and positive contributions which can be made by the anthropologists to projects, lead me to suggest this untapped resource on information on alcohol should be drawn upon elsewhere in the Third World and put to work for a worthy cause."

THE BACK PAGE

Parents reluctant to confront nuclear issues



By Mark Kearney

TORONTO — The threat of nuclear war is one reason young people are turning to alcohol and drugs, says a Harvard professor of psychiatry.

Lester Grinspoon says many young people feel such a war is inevitable. Their sense of hopelessness and helplessness has led some to indulge because they believe drugs and alcohol enhance their feelings of "living for the present."

"Nuclear war is not the major factor," but there is some correlation, Dr Grinspoon told **The Journal** in an interview.

"You might suggest to them to build for the future. 'What future?' they ask."

The fact many feel they can't discuss the issue with their parents tends to leave them feeling even more isolated, he says.

And while there have been no studies of the possible association between the threat of war, and alcohol and drug consumption, Dr Grinspoon suggests studies are needed.

Dr Grinspoon chaired a recent symposium here on the threat of nuclear war. It was held in association with the annual meeting of the American Psychiatric Association.

He termed the possibility of nuclear war "the most important crisis that has ever faced humanity."

Yet, parents and other adults seem reluctant to confront the issue.

"Many people repress their fear, anger, and rebelliousness in response to the nuclear threat; indeed, they anesthetize themselves. They avoid acquiring information that would make vague fears specific enough to require decisive action."

He says this must be changed if any impact is to be made on the threat of war, and subsequent problems, such as alcohol and drug abuse, that it might help cause.


Grinspoon: build for the future.

Understanding the threat, he says, "forces us to become more sensitive to the increasing extent to which our young children and adolescents perceive the threat of nuclear extermination as part of their lives, and how these young people, who see themselves as having an endangered future, retreat into the present.

"And we cannot ignore the possible consequences for their development of this retreat."

Adults and parents must lead the way, he says, because "we created the problem."

Other speakers at the symposium painted a picture of nuclear proliferation which helps to explain the feelings of helplessness and hopelessness among young people.

Astronomer Carl Sagan said no issue was more urgently in need of solution than the threat of nuclear war.

If a nuclear attack occurred, it would cost more than the entire gross national product of the world just to treat those who survived with radiation burns, Dr Sagan said.

Bernard Lown of the Harvard School of Public Health said the destruction and disease that would result from nuclear attack would be so great that "physicians have nothing to offer to this calamity."

There wouldn't be enough facilities or physicians to care for the radiation burn victims, he said. So it makes little sense to talk about ways in which survivors could be helped.

Dr Lown said thousands of physicians in North America have supported a proposal stating that their dedication to health care must involve speaking out against increasing the possibility of nuclear war.

Vol. 11 No. 6 2nd Class Mail Reg No. 2776 TORONTO, June 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

More money, less rhetoric needed for global drug war: US

By Harvey McConnell

WASHINGTON — Tangible international support to combat drug trafficking and abuse has not kept pace with the rhetoric, and the response of many countries does not match the problem.

Dominick DiCarlo, United States assistant secretary of state for international narcotics matters, said: "Anyone reading the data on drug abuse around the world must conclude that it is in the self-interest of all nations to control production and trafficking in their territory, and to share in the international responsibility for supporting demand and supply eradication programs."

He told the House of Representatives committee on foreign relations that heroin imports into Europe rival those into the US. Europe now has an estimated 225,000 to 350,000 heroin addicts compared with an estimated 450,000 in the US, "and overdose death rates in countries such as Italy, Denmark, and Germany are comparatively equal to, or greater than, in the US."

The incidence of heroin addiction in countries such as Malaysia, Thailand, and Burma is considerably higher than in the US.

These examples confirm drug abuse is a problem for both industrialized and developing countries, including producer and transit countries, and drug abuse is not just a US problem.

Mr DiCarlo added: "There are indications that this spreading misery has made a number of producer and transit nations more conscious of the impacts of drug abuse on their people, and conditions have improved for initiating projects."

However, "the support of the world community does not match the problem."

Mr DiCarlo noted only the US, the Federal Republic of Germany, Sweden, Norway, and Australia contribute $500,000 or more a year to the UNFDAC (United Nations Fund for Drug Abuse Control).

The UNFDAC recently received Canada's contribution for this year of $250,000 (US$200,561 at current exchange rates). Between 1971 and 1980, Canada's total contribution to the UNFDAC was US$1,480,722, compared to the US figure of US$29,120,000.

US efforts can only be as effective as the strategies and programs of the governments with whom the US collaborates.

Mr DiCarlo says he shares the conviction of his colleagues that "we must continue the strategy of applying pressure at all points in the grower-to-user chain — through effective treatment and prevention; through intensified investigation and prosecution; through increased seizures of both drug products and financial assets; and through crop control."

There is need for a more balanced narcotics control pro-

(See — All — page 2)

Deadly drug-smuggling trick on increase

WASHINGTON — A startling increase in people trying to smuggle cocaine into the United States via the "body packer" method has been found by United States customs agents at New York's Kennedy International airport.

Anthony Liberta, area director of the service at Kennedy, told a session of the House of Representatives select committee on narcotics abuse and control that the false bottom suitcase is still a favorite smuggling trick.

However, this is giving away to the dangerous "body packer" method whereby smugglers swallow balloons or other devices filled with narcotics. In one six-week period recently, customs arrested 23 people at Kennedy who tried to bring in cocaine from Colombia this way.

Although this method is the most difficult for customs men to detect, they arrested six people on one flight arriving from Colombia, and all were found to have packets of cocaine in their bodies.

Mr Liberta said: "A total of 27 pounds of cocaine has been seized in these most recent attempts to elude detection and find new cocaine trafficking routes from Colombia."

(The "body packer" method is extremely dangerous: several smugglers in the past have died of toxic overdoses when the balloon or condom containing cocaine or heroin ruptured in the digestive tract.)

Heading for the nineties

This is the 10th anniversary issue of **The Journal**. Some readers have been with us since the beginning — June, 1972. Others have joined since then. To all, we say thank you for your continuing interest, support, and encouragement. And, we invite you to mark our 10th anniversary with us.

Special features begin on page 7 where you will find the Names and Faces of some of the people who help build **The Journal** each month. On pages 8 and 9, we look back over 10 years in the addictions field. On page 10, you're invited to enjoy Wayne Howell's first, major attempt at "investigative reporting." And, on page 11, Richard Gilbert pulls us all into the future with a serious look at what might be happening in this field in 1992. As he does annually, Yardley Jones has drawn a special anniversary cartoon (page 6).

The Editor

US nuclear plants on drug alert p2

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NEWS

Briefly...

AA from A to Z

TORONTO — Alcoholics Anonymous (AA) is flourishing and growing in some 110 countries from Antarctica to Zimbabwe, concludes a recent survey by AA's general service office. The United States has the highest number of members with 455,505. Montserrat, Sierra Leone, and Somalia have one member each. There are an estimated 64,244 members in Canada.

More science

ROCKVILLE, MD — The United States Food and Drug Administration's planned merger of its drug and biologics bureaus may result in drug regulations that are rooted more in science and less in bureaucracy, believes previous FDA commissioner, Dr Jere E. Goyan. Dr Arthur Hull Hayes Jr, the FDA's current chief, says pediatrician, Dr Harry M Meyer Jr, a working scientist and current director of the Bureau of Biologics, will head the combined unit. Says *Medical World News* (Apr 12), nearly all of the 1,000 staffers at the current Bureau of Drugs "stick to their desks," and have no laboratories at headquarters. Three-quarters of the biologics workers are active lab investigators.

Superman's efforts

TORONTO — Evidence that girls smoke more than boys these days, and are harder to convince that smoking is a risk to their health, has prompted the Scottish Health Education Council to design a series of anti-smoking TV commercials that feature Superman rescuing damsels in distress. A recent survey revealed that among 12- and 13-year-olds, 37% of girls smoked compared with 24% of boys, says an article published in *Medical News* (April 29).

Life behind bars

MIAMI — A 51-year-old ophthalmologist, who dispensed marijuana and methaqualone for his patients, will be viewing life from behind prison bars. Dr Frederick M. Blanton began a provisional 20-year term here after being convicted of obtaining and dispensing some 300,000 methaqualone pills without United States Drug Enforcement Administration approval. Dr Blanton, who is planning an appeal, first riled drug enforcers eight years ago by giving marijuana-laced brownies to glaucoma patients. He said that, and the methaqualone dispensing, were for research.

'30' for The Reporter

WASHINGTON — A lack of manpower and government financing has forced an end to *The Reporter*, the newsletter for United States federal employee health and alcoholism/drug abuse programs. The 13-year-old newsletter ceased publication with its March issue. However, the Office of Personnel Management, which was responsible for *The Reporter*, says it will continue to help agencies to improve their employee assistance programs for alcoholism, drug abuse, and mental health problems.

Reagan's crisis management criticized

Northeast fears Florida drug ricochet

By Harvey McConnell

NEW YORK — Many officials in New York and other northeastern cities in the United States are worried that the increased war against drug trafficking in South Florida will worsen their problems.

The situation was viewed with enough alarm by NY Congressman Leo Zeferetti, that he held a hearing here of the House of Representatives select committee on narcotics abuse and control, which he chairs.

The clamp-down against drugs in Florida has meant a massive shift of equipment and law enforcement officials to that state and has resulted in a number of successes (**The Journal**, April). At the same time, US President Ronald Reagan's budget has made significant cuts in federal drug law enforcement budgets.

Congressman Zeferetti said at the hearing that "if federal law enforcement is drawn away from New York, the heroin crisis will worsen, and New York may very well become an entry point for marijuana and cocaine as the trafficking in these drugs moves up the eastern coast from Florida."

In the New York area, three of six assigned Coast Guard cutters are being moved to Florida, and two others will be out of action for regular maintenance. Thirty customs agents from New York have been transferred to Florida.

Congressman Zeferetti said the Reagan administration "unfortunately is addressing the problems of drug trafficking with a crisis-management approach by shifting, rather than increasing, resources. This quick reaction may temporarily show results in a particular area.

"The trafficking, however, will never be stopped until it is attacked on all fronts with sufficient personnel and assets to do the job."

District Attorney Robert Morgenthau of New York county, and Sterling Johnson, special narcotics prosecutor, said in a statement to the committee that the recent, tremendous rise in violent crime is related to increased availability of narcotics, specifically heroin. "In New York City, the crisis that we predicted in 1980 is now upon us."

They said there is more heroin than ever in the streets and this had led to more crime. "Unfortunately, in the face of this crisis, the federal government has cut off funding for New York City narcotics enforcement, prosecution, court, and jail programs."

Daniel Courtenay, chief of organized crime control, New York City police department, said that in narcotics enforcement "we are merely fighting a battle of containment, and any hope of overcoming this dilemma is far into the future."

Zeferetti: heroin crisis will worsen in New York.

New York is flooded with marijuana as well. Despite thousands of arrests each year "the city is plagued with a small army of marijuana dealers who infest our parks, commercial areas, and amusement centres.

"We are now inundated with 800 'smoke shops' or bogus stores operating throughout the city that deal marijuana on a continuing basis. Many of these shops are close to schools and have been the subject of numerous complaints from parents, educators, and concerned community groups," added Mr Courtenay.

Care gets sickest drinkers off dole and back to work

By Harvey McConnell

WASHINGTON — Alcoholism treatment programs can get many people off welfare and back to work.

"This is not news to many treatment program directors because they have always thought this, but for the first time we can give them clinical evidence that this is so," says Norman Hoffmann, PhD, director of the Chemical Abuse/Addiction Treatment Outcome Registry at the St Paul Ramsey Hospital.

Dr Hoffmann bases his conclusions on a study he and colleagues conducted on nine private and public alcoholism treatment programs in Minnesota and Wisconsin over the past two years.

At present, more than 4,000 recovering alcoholics are included in the study, and analysis has been made on 1,020 inpatients who have been followed up for at least 12 months.

He told **The Journal**: "We have found — and don't forget these people are the sickest, at the bottom of the treatment barrel — that 20% were on welfare when they came in. This drops to 9% six months after they have been discharged, and down to about 5% at the end of 12 months.

"These people are getting 'off the dole' and paying into the system.

"This is good, clinical observation, not empirical evidence. Until now, public program directors could not go to their state legislatures and say they were saving the state money. They couldn't prove it, even though they knew it. Now they can."

Dr Hoffmann, a clinical psychologist, says he and his colleagues function as "external auditors. We are not in the treatment field. We look at what happens to patients after they leave treatment."

Until the study, he had never been involved in the substance abuse field, "and I don't have any treatment axe to grind: AA (Alcoholics Anonymous), aversion conditioning, or anything else."

The study shows that in addition to people going back to work, there is less use made by them of the health care system. "We have found, for example, a 40% drop in medical and psychiatric-related problems, a 35% drop in outpatient visits to the doctor, and an 85% drop in arrests."

The study has found that some 50% of the patients had problems related only to alcohol, 45% to alcohol and other drugs, and 5% who claimed they were not drinking on admission. A 12-month follow-up found 50% had been totally abstinent. Another 15% had been totally abstinent in one or other of the six-month periods.

Only 5% were found to be drinking every month of the 12-month period.

Injury and illness visits to the doctor dropped, but not those needing surgery. Many of the patients had delayed treatment for conditions they had before going into treatment.

Overall, 25% had medical problems unrelated to detoxification when admitted, and this dropped to around 14% after discharge. Dr Hoffman: "This is still high, but it makes sense as a patient with cirrhosis, for example, is not going to have it cleared up in six months."

Dr Hoffmann says that so far, it appears about 10% of those admitted to programs do not complete them.

All nations must take part in world drug war: DiCarlo

(from page 1)

gram, not only between crop control and interception, but also in terms of the number of countries supporting the international effort.

"We must ensure that there are adequate programs involving the major producer and transit nations.

"There is need, not only for the industrialized and other donor nations to make a larger contribution to bilateral and multilateral projects, but for these nations to focus on other drugs as well as heroin, and for their efforts to be extended to all geographic spheres of production. And, again, there is the need to impress upon the governments of all producer and transit nations their national responsibilities."

Mr DiCarlo said there is some reason to be optimistic that US international efforts are having an effect, "not that we are solving or eliminating drug abuse."

However, he concluded, "we are making progress in our more realistic objective of controlling the production and distribution of major illicit substances. We do not have control, but we have improved the possibility that we will gain control."

Nuclear power plants on drug alert in US

TOLEDO — There has been a dramatic increase in drug-related arrests at United States nuclear plants in the past year. This is the message the Nuclear Regulatory Commission (NRC) is sending to all nuclear power plants in the US.

The warning is couched in a so-called Inspection and Enforcement notification which the NRC uses to alert plants about equipment failures and other safety matters.

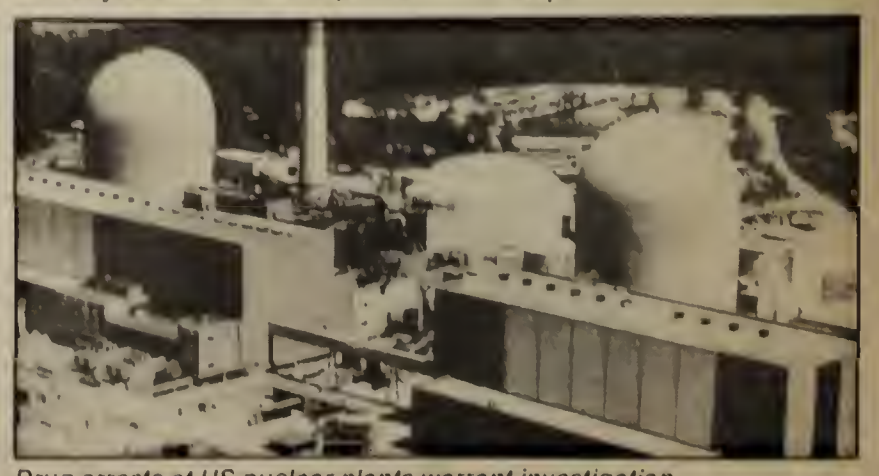
While there was only one drug-related incident in 1979, the present rate is now two new cases a month. But the seriousness of the incidents in terms of safety far outweighs their number, say NRC officials.

Incidents have involved people reporting to work while under the influence of illicit drugs, using drugs, or having drugs in their possession while on the job.

Spokesmen for Atomic Energy of Canada Ltd, and Ontario Hydro in Toronto, said there have been no incidents of drug abuse, possession, or arrests at nuclear sites in Canada.

Marijuana was the drug most frequently involved at the US sites. But there also were incidents involving amphetamines, cocaine, hashish, phencyclidine, and methaqualone.

"Given the alarming increase in reported drug-related incidents, the wide range of personnel implicated, and the pervasiveness of the reports on a national basis, the office of inspection and enforcement has established a drug abuse task force to address the problem on an industry-wide basis," the NRC says.



Drug arrests at US nuclear plants warrant investigation.

NEWS

US aid being doled out carefully

SA cocaine producers shifting operations

By Harvey McConnell

WASHINGTON — Patterns of cocaine production are starting to change in South America with some Bolivian traffickers refining coca paste and Colombian traffickers cultivating the coca bush.

(South America is the chief source of the world's supply of illicit cocaine.)

At the same time, United States activities in Bolivia — which stopped following a 1980 coup there — have started to resume under a government which came into power seven months ago, and agreement has been reached to fund an experimental herbicide eradication program against the coca bush.

Dominick DiCarlo, assistant secretary of state for international narcotics matters, outlined the developments in a report on US international efforts against drug trafficking in testimony to the House of Representatives committee on foreign affairs (see page 1).

He said that in developing US strategy, as well as in negotiations with producer nations, "we are well aware that the financial incentives favor illicit drug cultivation and our strategy must include either alternative financial incentives, such as economic development programs, or disincentives, such as arrests, seizures, forceful eradication, and other control measures that increase the risks for the farmer and producer, or both incentives and disincentives."

In reviewing production of cocaine, Mr DiCarlo said the government of Bolivia "is aware that an effective narcotics control effort is the prime requisite for a resumption of US economic assistance."

Royal non-smokers

The Prince and Princess of Wales, no strangers to honors, have had yet another title bestowed upon them. The National Society of Non-Smokers Britain has named the royal couple the most popular non-smokers for 1981.

In Peru, the other major source of coca leaves, the government is cooperating in efforts to intercept traffickers. "But like other producer countries, (Peru) faces the obstacles of corruption and inadequate resources." The major share of the 1983 US budget program in Peru is for support of an eradication program in the upper Huallaga valley, the largest source of illegal coca leaves, and this campaign will be complemented by a five-year, US-aided rural development project.

"Our assessment is that the Peruvian government is attempting to control coca production and interdict trafficking, and that this is a promising effort," said Mr DiCarlo.

Similar cooperation is being given by the Colombian government — not only against cocaine, but also against marijuana trafficking. Mobility from US-supported helicopters has produced effective moves against coca bush cultivation and many cocaine refining laboratories.

Funds for drug abuse education programs, as well as for interception of cocaine trafficking, have been given to Ecuador, an important link country in the movement of coca paste from Peru and Bolivia to Colombia.

Modest support is being given to Brazil for police action at selected border areas as the country is showing evidence of becoming an important cocaine transit country. Brazil is also the principal source of acetone and ether used in cocaine refinement in Bolivia.

In Mexico, the government increased its opium eradication efforts when indications of expanded cultivation appeared recently. The bulk of US support is for the 87 planes used in aerial herbicide dusting.

The US is developing a system of communications using both satellites and shortwave radio, and operating in both Spanish and English, for cooperation among narcotics enforcement organizations in the Caribbean and Central America.

Haiti is being given aid to develop a maritime interception effort against trafficking, and discussions are being held with Jamaica on a future eradication and interception project for marijuana.

In the Far East, the assessment by the US of programs in Thailand is mixed. In January, the Thai government took forceful action against the dominant opium-refining and trafficking organization in the Golden Triangle and cut the availability of chemicals needed to refine opium.

"On the other hand," said Mr DiCarlo, "the Thai government has failed to enforce the opium poppy ban even in areas which have benefitted adequately from the United Nations crop substitution program (**The Journal**, March). Actions are needed to consolidate and expand disruption of trafficking."

He said: "Burma is slowly emerging from its self-imposed isolation, and cooperation on narcotics control issues has been a major aspect of our improved relationship with Burma." The US is giving aid to security forces, but they face a difficult task as the government does not exercise control over most opium-producing areas.

Next month:

Cocaine Today

Union/gov't develop EAP for Ontario's civil servants

TORONTO — The Ontario government and the union representing most of its employees have developed a scheme to deal with employees' personal problems such as alcohol and drug abuse that impair job performance.

The employee assistance program will offer confidential, professional advice and counselling for mental, financial, psychological, legal, social, and work-related problems.

In the past, workers with serious personal problems were fired or suspended. By law, the Ontario Public Service Employees Union (OPSEU) which represents some 55,000 civil servants, must defend members through the mechanism of the grievance procedures. In theory, that's fine. In practice, although the union frequently wins and the employee goes back to work, nothing is done to deal with the problem that caused the trouble.

"It's been a no-win situation," says Mark Poudrier, the Addiction Research Foundation regional director who is acting as an advisor to the joint union-management committee developing the program.

Two pilot programs, run in North Bay, were highly successful. In both, supervisors and union stewards were trained to spot problems and refer them to the appropriate professionals before a crisis developed.

Not only did the number of grievances drop dramatically, the lines of communication opened between management and the union were carried over to the local bargaining table where these same communication skills proved helpful, union spokesman Dennis Arsenault said.

The inaugural program will begin soon and the union is optimistic that by the end of the first year, four or five will be in operation in the ministries of corrections, health, community and social services, and transportation. Ultimately, it could be extended to all employees of Ontario crown corporations.

The program will be voluntary. No records will be kept on workers who seek counselling.

Wayne Howell's column appears on page 10 as part of The Journal's 10th anniversary special section.

Nicotine may reduce 'sweet tooth,' smokers like bland diet: study

TORONTO — Nicotine may help smokers stay slimmer — not by depressing appetite in general, but by depressing the desire for sweet foods, suggests a study in press in *The International Journal of Addictive Behaviors*.

Neil Grunberg (PhD), assistant professor of psychology at the Uniformed Services University of the Health Sciences, Bethesda, MD, told **The Journa**l about his findings with, first, a rat study and, then, a human study investigating the effects of nicotine on food preference.

In the animal experiment, Dr Grunberg found rats given a constant infusion of saline solution gained weight normally when fed a diet of bland lab chow and various glucose solutions. But, rats receiving nicotine infusion gained less weight or none at all, depending on the intensity of the nicotine solution.

Furthermore, Dr Grunberg and his colleagues found, rats receiving nicotine kept eating lab chow at the same rate that their saline-receiving peers did, but cut down on their glucose intake in a dose-response relationship. The more nicotine they got, the less sweet solution they ate.

In human experiments, Dr Grunberg gave non-smokers, smokers in partial withdrawal (they had been asked not to smoke for 12 hours prior to coming to the lab), and smokers who were free to smoke, a choice of snacks.

What was being measured was how much each subject ate of which type of food.

The human study provided what seems to be a striking replication of the rat results.

The smokers who were free to smoke and presumably had the highest nicotine levels ate as much of the bland foods (Munster cheese, non-salted peanuts, non-salted crackers) as did the other two groups, and also ate similar amounts of some salty foods (pretzels, salted peanuts, salami) that were provided.

When it came to sweet foods, however, the smokers had significantly less interest in the available sweets (gumdrops, coffee cake, chocolate) than did the non-smokers.

The smokers with partial withdrawal, and with presumably some nicotine in their systems, fell between the other two groups, though they resembled the smokers more than the non-smokers.

"It has been widely held or believed," Dr Grunberg told **The Journal**, "that nicotine suppresses appetite. The studies we are doing suggest, though, that nicotine and smoking don't affect general appetite as much as they affect, selectively, the consumption of certain kinds of food. Changes in the consumption of specific foods may be behind the body weight changes that people observe when they stop or start smoking."

Research/patient-care 'a difficult balance'

TORONTO — A patient's right to well-being and care should supersede any benefit a community might receive from research on that individual.

Abbyann Lynch, an associate professor of philosophy at the University of Toronto, says "it's wrong to use people as things." They should not be coerced or unknowingly used as research or educational tools while being treated. However, there can be exceptions if the patient's desire for well-being may result in something illegal or harmful such as suicide, she said.

It's a difficult balance to strike, she told researchers at a recent seminar at the Addiction Research Foundation.

Hospitals usually strive to do their best in three areas — patient care, research, and education for future staff. Too often these goals, by their very nature, conflict with each other, Dr Lynch said. There is the right of the patient to receive the best care versus the long-term benefit a community might receive from research into other forms of treatment.

There is also conflict with students' needs to observe and learn from a patient who is "an interesting case," she added.

"Can they learn by reading or do they need to learn by doing?" Dr Lynch asked. What is needed is a system to balance ethical issues as they arise.

One aid to decision-making is the patients who grant consent, she said. A patient may realize certain forms of treatment are riskier or more unpleasant than others but will consent for the good of society.

Dr Lynch told **The Journal** that if all patients stood by their right to care and well-being it might be difficult to do any research. "But by and large people do see that co-operation (for research and education) is needed."

NEWS

Hyper kids on R_X stimulants back off recreational drugs

TORONTO — Hyperactive children treated with stimulant medication are less likely to become involved with drug and alcohol experimentation than are hyperactive children who never receive drug treatment, a study indicates.

The findings run counter to the hypothesis that drug treatment of hyperactive children increases the tendency to drug abuse in later life.

The children, who average 15 years, have been followed for an average of five years and will be assessed again when they reach 21 years.

The purpose of the study is to assess long-term effects of treating hyperactivity with stimulants in childhood and early teenage years, said Jan Loney (PhD) in a telephone interview with **The Journal**. Dr Loney is director, child psychology research program, department of psychiatry, University of Iowa Hospital, Iowa City, IA.

The study focuses on detecting differences in outcome with regard to drug and alcohol use.

Of 51 children assessed in the present phase of the study, 26 had at some point received medication for hyperactivity (for an average of 25 months); 25 had received brief psychological treatment but no drugs.

The recent assessment of the children, using both comprehensive interview and a wide variety of self-report instruments, indicated that, in most areas, there were only minor differences between the two groups but in the area of drug experimentation some sharp contrasts emerged.

Children who had received drug treatment were significantly less likely to have friends who had asked them to try marijuana, less likely to have experimented with marijuana, and less likely to have tried illegal tranquillizers. They also reported drinking less alcohol and showed more disapproval of hard drugs.

"The idea has been," Dr Loney explained, "that the kid who was taking drugs for hyperactivity would come to think, 'That's swell, it must be okay to take drugs in order to feel good.' It seems though, from our data, that this is not what happens at all. If anything, the effect is in the opposite direction."

Among children who had received medication, some say they have abused Ritalin. And some parents feel their child has been introduced to drugs through medication for hyperactivity, she said.

"In general, however, the group that was given medication is *less* likely to try drugs rather than more likely."

In addition to a higher incidence of experimentation on the part of the unmedicated children, there were also more instances of heavy use of alcohol and marijuana among these children.

There are two major hypotheses about the apparent long-lasting or residual benefits of having taken medication at some point, Dr Loney said.

"One would be that medication makes kids less impulsive, let's say, and thus some kids are less susceptible to experimenting with drugs and alcohol because their behavior is generally improved," she said.

"The other possibility is that the kids who are taking medication come to view all drugs in general as negative, as a form of externally-imposed control of behavior, and for this reason they back off from taking drugs in a recreational way. Also, kids get teased because they are on speed. So there's a combination of factors that might make kids very spooky about drugs in general."

Dr Loney hopes that the final follow-up, which will involve interviews and questionnaires will help clarify the question of adult outcomes for hyperactive kids.

WHO study focuses on non-students

TORONTO — School drop-outs are heavier drug users than students because they have "special social and personal problems that predispose them to drug use," a World Health Organization (WHO) study has revealed.

The study identifies the obvious reasons why this occurs — no jobs, hanging around with bad company, too much time on their hands — but fails to provide any answers.

The WHO justifies the report, however, by arguing that there are few data on drop-outs since most studies focus on student drug use.

"I wasn't surprised at any of the findings," said Reginald G. Smart, an Addiction Research Foundation scientist who helped coordinate the study.

"What I hope it will do is pinpoint some problem areas in the countries where the survey was done and that this information will aid governments and agencies in finding solutions to the problems."

More than 2,000 young people in Pakistan, India, Malaysia, Mexico, and Canada were surveyed over a three-year period. Most were found to be light drug users, and few needed special treatment for their problem. (A light user was defined as someone who had not taken drugs either daily or weekly in the month before the survey was taken.)

By contrast with students in Western industrialized nations — most of whom stay in school until age 16 or 17 years — the report found that students in developing countries often leave school earlier.

It found that cannabis was the most popular drug except in Malayasia where opiates were used most frequently. (Alcohol was not included in the study because it's not as great a problem in some developing nations.)

In Pakistan, where only heavy users were surveyed, 83.9% used cannabis in the past year. In Canada, where a more random sample was taken, 31.5% had used it in the same period.

Dr Smart admits the Pakistan statistics could be misleading when compared to other countries, but argues they're useful to give the WHO an idea of drug consumption and habits among heavy users.

Cda/US form research group

Brewers join forces to 'prevent alcoholism'

TORONTO — The newly-formed Alcoholic Beverage Medical Research Foundation is gearing up to "contribute new knowledge toward the prevention of alcohol misuse and alcoholism," says Thomas B. Turner of Johns Hopkins University.

The foundation is a joint project of the Brewers' Association of Canada and the United States Brewers' Association (USBA). It will operate on a $1 million grant this year. Most of the money is expected to go to research grants to study such things as factors influencing the transition from moderate to excessive drinking, and components of alcohol-related traffic accidents.

Dr Turner, who heads the four-month-old foundation, says the joint project has "great potential" because it will allow researchers and industry officials to use the resources in both Canada and the US. The foundation will be administered by a 17-man board of which 10 are public members, and seven are from the industry.

The foundation is an expansion of the USBA's Medical Advisory Committee which Dr Turner directed. However, by combining the interests of the two countries, more co-ordinated research can be done, he says.

"We're all working for the same thing," he told **The Journal**. "And that is to try to reduce the abuse of alcohol. We all agree alcohol abuse is a bad thing and we're hoping to do something about it."

Dr Turner says he doesn't see any problem in maintaining objectivity in the research just because two brewers' associations are funding the project. Scientists have to consider their reputations and there has never been interference or pressure from the USBA in the past, he said.

He says he doesn't know if there will be research into the effects of advertising or educating the public about alcohol misuse. However, people are interested in the drinking-driving issue and more research is needed to provide better — and less ambiguous — statistical evidence about alcohol-related traffic accidents, he says.

Anti-smokers now courting health pros

LONDON — Britain's abrasive anti-smoking pressure group ASH (Action on Smoking and Health) is adopting a new strategy. Instead of outright confrontation with the tobacco industry it seems to he wooing health professionals.

The new approach appears with publication of *Smoking Prevention — a Health Promotion Guide for the National Health Service* which contains, among other things, model policy statements and suggested resolutions on smoking which may be used by local health groups.

Sir John Brotherston, past president of the Faculty of Community Medicine says the book has been designed for people who are well aware of the problems yet have little idea of how to tackle them.

"It is hoped that not only will it he widely used but that future editions will incorporate much additional material ohtained from successful experiments around the country."

More than 10,000 copies of the book have been distributed to community physicians and health authority officials and publication was timed to coincide with a reorganization of the National Health Service which took effect on April 1.

David Simpson, director of ASH told the The Journal: **"It is obvious the NHS (National Health Service) should take the lead in fighting Britain's largest preventable cause of illness and death."**

RESEARCH UPDATE/ Austin Rand

A powerful duo?

It has frequently been noted that regular consumption of alcohol may have a protective effect against heart attack. Acetylsalicylic Acid (ASA) may have similar benefits. In Canada, the Bayer form of ASA, called Aspirin, has recently been granted approval as a medication for warding off second heart attacks in men. It now turns out that alcohol and ASA (aspirin in the journal article precised here) combined may have a much more potent effect than either does separately. Daniel Deykin and colleagues at Boston VA Medical Center gave nine volunteers 50 grams alcohol (about $1^3/_4$ ounces), 325 mg aspirin (one tablet), or the two medications together, and then measured the effects on bleeding time. Alcohol produced a negligible lenthening, not significantly different from baseline at any time. Aspirin alone significantly increased bleeding time until 24 hours after ingestion. The two together, however, produced a significant lengthening of bleeding time for 96 hours, with a much higher and more sustained peak than with aspirin alone. The researchers speculate that the beneficial effects ascribed to alcohol may be due in part to its synergistic effects with aspirin, which is also present in many people's systems. They warn that individuals are highly variable in their reaction to the aspirin-alcohol combination — in some people, aspirin plus "several ounces" of alcohol could provoke spontaneous internal bleeding.

New England Journal of Medicine, April 8, 1982, v.306 (14):852-854.

Cotinine in amniotic fluid

When pregnant women are exposed to passive smoking, cotinine appears in the amniotic fluid, though lengthy or frequent exposure is required for "appreciable amounts" to be detected, say researchers who have developed a sensitive assay for cotinine. Nicotine has a half life of only 30 minutes in the body, the researchers note, while cotinine's half life is 24 hours. This suggests the fetuses of smoking women, and of some women experiencing chronic passive smoking, are exposed to considerable amounts of the nicotine metabolite. The researchers, led by Brian Andresen of Ohio State University School of Medicine, found that all 15 smoking women tested had appreciable amounts of cotinine in the amniotic fluid, as did two of 24 women experiencing passive smoking. While passive smokers with occasional exposure did not seem to be affected much, the researchers say work is needed to determine the extent of the fetus's exposure to combusted tobacco products. They note that, in the third trimester, amniotic fluid becomes more acidic and is particularly likely to act as a trap for alkaloids in the mother's inhaled air.

The Lancet, April 3, 1982: 791-792.

Smoking and caffeine

It is frequently observed that coffee seems to stimulate desire for a cigarette. But, whatever the connection, it's probably not a direct pharmacological effect of caffeine, suggests a study by I. D. Chait and R. R. Griffiths, Behavioral Pharmacology Research Unit, Baltimore City Hospitals. The researchers had male and female smokers read or watch television in an isolated room for 90-minute sessions on five different days. Sixty minutes before each session began, the smoker took either a pill-form, acute dose of caffeine (50 mg to 800 mg) or a placebo. Number of cigarettes smoked, number of puffs taken, total time spent puffing, and post-session carbon monoxide in the subject's breath, were all used as measures of how much smoking the volunteer had done. Caffeine doses had an effect on hand tremor, measured post-session, but had no effect on, and in some cases actually decreased, amount of smoking. Using the design to test effects of amphetamines, the researchers found that a 25-mg dose reliably produced increases in smoking, demonstrating that caffeine and d-amphetamine have different effects on human smoking behavior and suggesting that caffeine intake does not, at least by any pharmacological means, increase cigarette consumption.

Federated American Societies for Experimental Biology: April 1982, New Orleans.

NEWS

Teens see aftermath of drug-related accidents

Nurses hold anti-drug classes in trauma units

By Harvey McConnell

WASHINGTON — Nurses at a Maryland shock trauma unit became so disturbed by the number of teenage patients involved in alcohol- or drug-related accidents that they set up their own adolescent education program.

The program has become successful in the past two years, and a number of counties in the state have asked to copy the idea, says Beverly Dearing, a nurse at the Maryland Institute for Emergency Medical Service Systems.

The 52-bed facility in Baltimore receives only patients with severe trauma transferred there from around the state. Many have been in automobile accidents.

Ms Dearing told the annual conference of the National Council on Alcoholism here that nurses became concerned as more and more young people aged 15 to 25 were being admitted with multiple injuries caused in highway accidents. More than 50% of the cases were associated with alcohol; either the patient had a high, blood-alcohol level, or had been the innocent victim of a drunk driver.

Many of these young people suffered some kind of permanent disability, and their families suffered severe stress, and, in many cases, economic hardship.

The nurses met with juvenile services administrators and came up with their program. The juvenile authorities refer to them young people they think will benefit from a visit to the centre.

Ms Dearing said the teenagers they see are 15 to 18 years old, and must have either committed a serious motor-vehicle offence related to alcohol or drug use, or been charged with possession of alcohol, or been involved in alcohol and drug use.

Their program includes discussion of the effects of alcohol and drugs on the body, a description of the shock trauma unit, viewing of a videotape on the centre, a discussion with a former trauma patient, and a wind-up session.

Ms Dearing said the young people are told what they will see: "many patients on respirators, many unconscious patients, and patients uncovered because of their need to be medically observed.

"Shock value is not intrinsic to the program."

Young people who become anxious and uncomfortable are told they can wait in the conference room if they choose.

The young people are taken to the critical-care unit where they often observe young patients either injured in alcohol or drug-related accidents, or who have a history of drug abuse. They are told of the injuries to the patients and the probable prognosis.

In an immediate-care unit they may talk to a patient involved in an accident related to alcohol or drug use. Ms Dearing: "Usually these patients are very vocal and willing to discuss their feelings regarding their accident."

The young people later talk to a patient who has recovered. They are encouraged to discuss their feelings and ways they think they can avoid peer pressure to use alcohol and drugs, and how to avoid driving if they do become drunk.

Ms Dearing said they hope to modify their program so that it can be included as part of curriculum in schools.

'BOOZE' — a comedy that has messages for teenagers

TORONTO — Ontario high school students are learning about the consequences of alcohol abuse from BOOZE.

BOOZE, a series of five skits, is the brainchild of Randy Sallows, a theatre arts instructor at Confederation College in Thunder Bay. The skits, performed by nine students from Thunder Bay high schools, satirize real-life situations where alcohol may be used or abused.

Ken Moffat of the Addiction Research Foundation branch in Thunder Bay says BOOZE is aimed at about 5,000 grades 9 and 10 students. They can identify with the problems of alcohol abuse when they see fellow students performing the skits using everyday language and humor to make a point, he told **The Journal.**

"It's like what Norman Lear (the television producer) says — 'when the audience is laughing that's when you're able to get the message through.'"

BOOZE was first performed about four years ago and audiences have twice been evaluated to see what effects such a presentation has on their attitudes, behavior, and knowledge of alcohol. Students filled out questionnaires a week before seeing the play and then a week after.

Mr Moffat says evaluations have suggested students favor alcohol abuse less and social controls more after seeing the play. They also seem to gain more knowledge from the play than they would from four classroom lectures, and show a short-term drop in alcohol consumption, he says.

Now, BOOZE, which toured the province in May, will be coupled with a survey on both short- and long-term effects. Students will fill out questionnaires as in the previous evaluations, but a follow-up study will be done a year from now, Mr Moffat says.

This year's tour cost $20,000 and was paid for by ARF, Wintario, and the Thunder Bay Rotary Club which initiated the program. The tour wound up with a performance in Toronto and was videotaped for future use.

"Our objective is to put together a how-to booklet so theatre arts students anywhere can take the script and the how-to booklet and do their own performance," he said. "We're hoping there may be other theatre performances in the future that will complement this."

Karen Lucas and Sean Jesseau of Thunder Bay rehearse a scene from BOOZE, a satirical play designed to educate students about the consequences of alcohol abuse. The two students were part of a nine-member troupe which toured Ontario in May.

US President vetoes plans for sterner labels on cigarette packs

WASHINGTON — Vested interests in tobacco-growing states, spearheaded by their Congressional mouthpieces, have forced President Ronald Reagan's administration in the United States to scuttle plans for stronger health warnings on cigarette packages.

Within 24 hours, officials from the US department of health and human services were forced to recant on testimony to legislators considering stronger health warning labels.

On a Monday, health department officials, in testimony cleared in advance by White House officials, voiced strong support for the proposed legislation. The next day, the officials had to knuckle under to administration pressure, and tell legislators the issue was still "under study."

The proposed legislation would put a variety of special health warnings on cigarette packages, such as the possibility of cancer and heart disease from smoking.

Canadian appointed AA Board chairman

TORONTO — Management consultant Gordon Patrick has become the first Canadian to be elected chairman of the General Service Board of Trustees of Alcoholics Anonymous (AA).

Mr Patrick, who is 64 and lives in Lyndhurst, Ont, is one of seven non-alcoholic trustees on the 21-member board. The other 14 are rehabilitated alcoholics. His term, renewed annually, is for a maximum of six years.

A former Toronto YMCA director who did counselling and community organizing for 18 years, Mr Patrick joined the Addiction Research Foundation (ARF) in 1958 to help develop a branch in Hamilton in a non-medical teaching centre.

In 10 years at ARF, he started the ARF's summer school, patterned on the Yale summer school of alcoholic studies, helped set up the scientific advisory board, and, as director of education, began the massive job of alerting companies that most alcoholics are employed. Mr Patrick later moved to the Ontario government and ran its civil service program on alcoholism for nine years.

He credits Donwood Institute founder Dr Gordon Bell, whom he consulted about an alcoholic brother, with what has become a passionate commitment to AA and fighting alcohol abuse. He is still a consultant to the Donwood.

Mr Patrick has been an AA trustee since 1975. "Part of the reason I got hooked on AA is that I found very intelligent people had such preconceptions, such stereotyped ideas about drunks, that the only way to get their attention was to have a recovered alcoholic come and talk to them. AA is an adjunct, not an 'in place of' solution, to professional help."

Girl glue sniffers prone to suicide?

TORONTO — A recent London (England) survey shows that a disproportionately high number of girls who sniffed glue attempted to commit suicide or mutilate themselves, says an article published in *Medical News* (April 29).

Richard Gilbert's column — Drug Abuse in 1992 — appears on page 11 as part of The Journal's 10th anniversary section.

Interviews with the 25 glue sniffers and 25 non-glue sniffers who participated in the survey showed no significant differences in family circumstances, but glue sniffers were more likely to be white and followers of the 'skinhead' cult, a group characterized by anti-authoritarian and rebellious behavior traits.

Twice as many glue sniffers (eight to four) tried to commit suicide, and 11 mutilated themselves, compared to three non-sniffers. Few girls used hard drugs, although a significant number in both groups misused soft drugs, many by experimenting with pills. Some also used alcohol with solvents to achieve intoxication.

Social worker Jill Dendle, who conducted the survey, concludes that solvent abuse has the earmarks of a current teenage fad with rebellious connotations, but warns: "Although glue sniffing may well be a passing phase for many of these girls, the potential risks should not be overlooked, and tentative links can be made with more severe underlying problems."

The British department of health said it is preparing a film on solvent abuse for parents and professionals and plans to consult retailers about the possibility of voluntary restraints on selling glue and solvents.

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Published by Addiction Research Foundation of Ontario
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In ethical judgements 'we learn as we go'

Nuremberg Code was a starting point

Dr Richard Gilbert's article Experimenting with Humans (**The Journal**, Jan) is to be welcomed for the contribution to the increasing awareness, among researchers and the public, of the ethical issues in research that involves human subjects.

As his article points out, the Nuremberg Trials stunned the scientific community with its revelations of brutality and inhumanity in the name of the pursuit of knowledge. The response of sober and responsible members of the research community was to support strongly the Nuremberg Code of Ethics, but more than this, to treat it as, essentially, a *starting-point* for a process of ethical scrutiny that has, for many years now, been an integral part of review procedures of most research institutions, including the University of Toronto. As a matter of fact, ethical deliberation is more searching, and its judgements more severe now, than the authors of the Nuremberg Code ever dreamed.

The intervening years have been a period of discovery, step by step, of the *implications* of that Code for research — implications of the kind that usually come to light in the course of examining concrete situations. What we recognize, as did Hippocrates' contemporary, Aristotle, is that ethical judgements are both deductive and inductive. We learn as we go along; with experience we move from one level of insight to another.

The two cases cited in Dr Gilbert's article exemplify admirably this situation. The fifth article of the Nuremberg Code prohibits research where there is an *a priori* reason to believe that death or disabling injury will occur: we note the exception, ". . . except, *perhaps* [italics mine], in those experiments where the experimental physicians also serve as subjects." It is certainly possible to imagine circumstances in which this exception is appropriate.

On the other hand, when an institution is involved, which has responsibility for considering the ethical implications of a course of action taken by one of its members in the conduct of research that that institution sponsors, it has to broaden its purview to include consequences of the action which go far beyond that individual physician-subject's own person. In other words, the ethical issues are seldom confined to the individual physician (researcher)-subject. This is what ethical judgement is up against, always something more than was apparent at first sight.

The problem of risk is another issue. The Nuremberg Code states the principle; and since there is some risk in most of what we do, we add into the equation the factor of benefit, and then consider both in relation to the individual subject as well as to the wider group of "potential" subjects, in other words, society. The relative "values" of all of these components in the ethical situation have to be assessed and balanced in every single case. Informed consent then takes these factors into account.

Finally, the question of recruitment of subjects: the main issue that underlies the policy of discouraging physicians from approaching their own patients to serve as subjects in their own experiments is that of coercion. On the other hand, coercion is a continuum — from a kind of attractiveness that we would barely call coercion at all (unless it is contrived) to outright physical force.

Somewhere along that continuum is the dividing line, particular to each case, between what is acceptable ethically and what is not. Where the line is to be drawn is determined by a variety of factors, including those of risk, benefit, whose experiment it is, *whether* it is experimental, how the patient is approached, what alternatives are available, and so on.

While ethical codes and ethical guidelines state principles to be honored, probabilities to be considered, and generalizations to be used, as ways of illuminating each concrete circumstance, the individual judgement remains an act of profound responsibility on the part of each review committee, and ultimately on the part of the researcher.

Human Subjects
Review Committee,
University of Toronto,
Chairman: Gordon A.B. Watson

Coleridge's account was a con

Wayne Howell is right on target when he says alcohol and other drugs are a bogus path to artistic vision and creativity (**The Journal**, April). However, Coleridge's *Kubla Khan* may not serve as the best example to prove the point. Dr Howell notes that it was written under the influence of opium, and that Coleridge himself discounted its merit, calling the poem a "psychological curiosity."

Not so, says Coleridge's biographer, Molly Lefebure, in *Samuel Taylor Coleridge: A Bondage of Opium*. Calling Coleridge's account of *Kubla Khan* a fraud, and a "small masterpiece of confidence trickery," Ms Lefebure says Coleridge was turned on "with a controlled touch, which suggests that mysterious but undeniable force, the creative imagination of the artist, rather than any substance from the druggist."

Elsewhere, Ms Lefebure points

(See — Drug — page 12)

Canadian doubly proud

I am the coordinator for the Fetal Alcohol Syndrome/Youth Alcohol Prevention programs for the New York State Division of Alcoholism and Alcohol Abuse.

I thoroughly enjoy reading **The Journal** every month, and, as a former Canadian, I am doubly proud of the work you are doing at the (Addiction Research) Foundation.

Shirley Burris, RN,
FAS/Youth Coordinator,
New York State Division of Alcoholism and Alcohol Abuse,
Albany, NY

NAMES AND FACES

Many people are involved in getting **The Journal** *to you each month. Some names, and even some faces, appear fairly regularly in our pages. Others don't — they're our advisers, our consultants, promotional people, and so on. This page of names and faces will help give you a better idea of who we all are and what we do. It's from all of us who help on* **The Journal** *to all of you who read it. As you read this special 10th anniversary page, imagine the sound of applause in the background. That's us saying thanks to you — for your interest and support.*

1972 • 1982 The Journal

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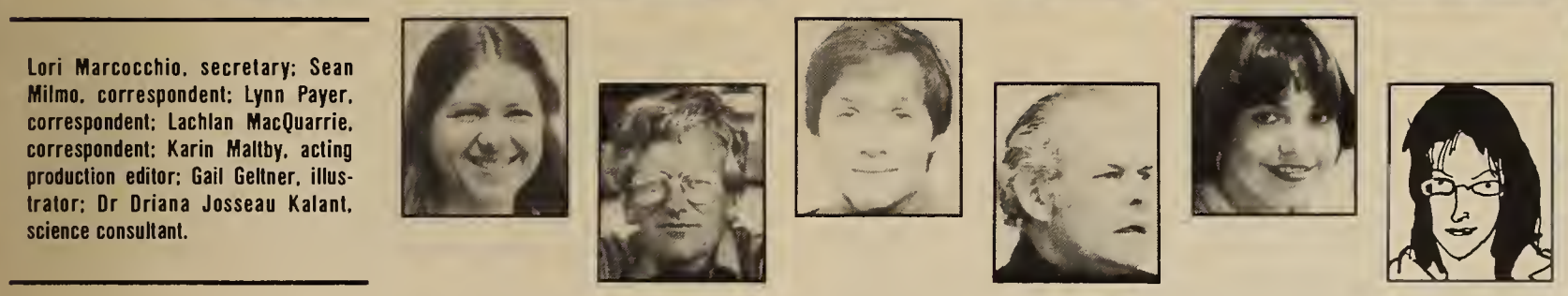

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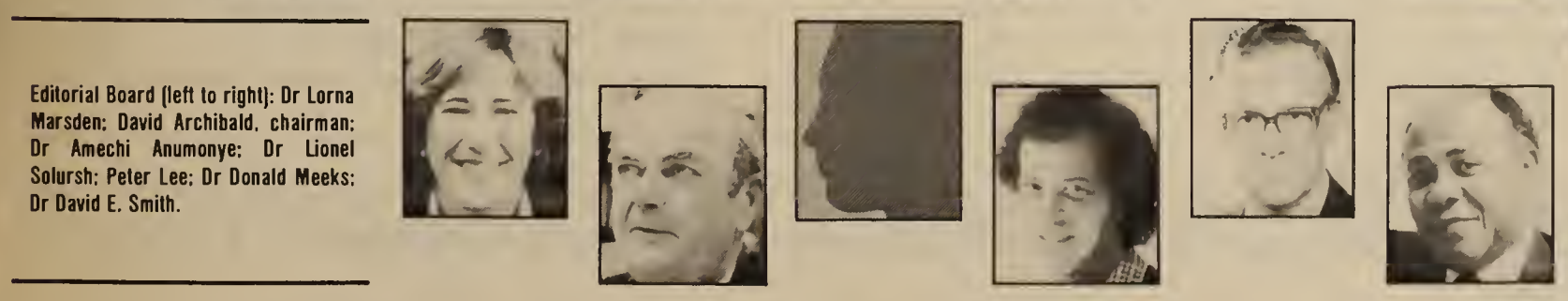

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1972 • 1982 The Journal

THE FIRST 10 YEAR

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Alcohol

Morris Chafetz

Most drinking problems arise as young people attempt to copy the drinking behavior of older peers and adults. Many of these problems can be reduced if we, as adults, accept our job of having young people learn about social responsibility; that is, about the responsible use of alcohol if they choose to drink and about responsible attitudes toward their peers who choose not to drink, **Dr Morris Chafetz**, director of the United States National Institute on Alcohol Abuse and Alcoholism, said (Aug '72). . . . **British social and medical workers** in alcoholism units report the growing impression that the incidence of problem drinking among women is rapidly rising (Oct '73). . . . By making the purchase of alcoholic beverages legal for 18- to 20-year-olds, it possibly increased the proportion of them who used alcoholic beverages, increased the frequency of drinking, and maybe even increased the amount of alcoholic beverages they consumed at one time, University of Western Ontario sociologist **Dr Paul Whitehead** said (Oct '74) . . . . Scientists at the **Addiction Research Foundation** and University of Toronto hope they have discovered a new medical technique to prevent alcoholic liver cirrhosis. It involves using the anti-thyroid drug, propylthiouracil (PTU), to reduce the speeded-up metabolism of livers exposed to heavy amounts of alcohol (April '75). . . . University of Washington doctors now rank the fetal alcohol syndrome (FAS) third — behind Down's Syndrome and neural tube defect — on the list of the recognized disorders featuring mental deficiency, **Dr David W. Smith** said (June '75). . . . To say that if you free women from their traditional roles you will not have alcoholism is as simplistic a trap as the antithesis of the argument that emancipating women leads them into evil ways, **Dr Edith Gomberg**, University of Michigan professor of social work, said (Oct '75). . . . **Saskatchewan** has maintained its reputation as an innovator in the area of health legislation by becoming the first jurisdiction in North America to raise the legal drinking age (to 19) after previously lowering it (June '76). . . . The suggestion in a **Rand Corporation** of California survey that there is a possibility that a recovering alcoholic might return to controlled drinking has drawn volatile response from many physicians, researchers, and, particularly, from the US National Council on Alcoholism (Sept '76). . . . Certainly drunk and disorderly behavior is tolerated less among women but it does not follow that the condition of alcoholism, and particularly the desire for rehabilitation, would be viewed the same way, ARF scientist **Roberta Ferrence** said (Feb '80). . . . There are cautious types who will never have a cigarette, a glass of wine, or an aspirin — and that is their right. Others will decide to have an occasional glass of wine — and that is their right, **Dr Ann P. Streissguth**, a University of Washington professor of psychiatry and behavioral sciences, said (June '80). . . . Despite earlier reports that they had reversed their published views, **Rand Corporation** researchers are sticking to their guns, insisting 'non-problem drinking' is a feasible goal for some alcoholics (Sept '80). . . . The population of Alaska drinks more — and drinks more frequently and heavily — than any part of the country with the possible exception of Indian reservations and big city ghetto populations, **Robert Cole**, coordinator of the Alaska Office of Alcoholism and Drug Abuse, said (Aug '81). . . . The **Ontario government** has cracked down on drinking and driving in spite of outcries from sections of the public and the media that to do so is a violation of civil liberties (Feb '82) . . . . Alcohol control policies are political footballs kicked around by governments and politicians trying to balance both the economic and health needs of the nation. Whether in the East or the West, governments are trapped in a conflict of interests which are economic, political, and social, a **World Health Organization** report from the International Study of Alcohol Control Experiences has shown (April '82) . . . . Eighty-five per cent of patients with mild to moderately-severe alcohol withdrawal and 60% of hospitalized patients in severe alcohol withdrawal can improve rapidly without any pharmacologic intervention, said a report by a group of **ARF researchers** (May '82).

Roberta Ferrence

Other Drugs

Since United States society has finally decided to do something about the drug problem — particularly heroin — the health profession has a real opportunity to make some inroads. If we fail, this country is going to see one fantastic enforcement effort. They're going to say, 'You failed, now it's our turn to move in,' **Dr Peter Bourne**, then director of the Georgia Office of Drug Abuse, said (Oct '72). . . . When used in the proper environment and properly administered, methadone is safe and efficacious insofar as it does reduce drug abuse, crime, and other anti-social drug-seeking behavior, in certain classes of opiate-dependent people, **Dr Jerome Jaffe**, head of the Special Action Office on Drug Abuse Problems, said (Dec '72). . . . Students are expert pharmacologists. They select a drug that acts specifically to help resolve a specific emotional problem, Manhattan psychiatrist **Dr Herbert Hendin** said (March '73). . . . **The LeDain Commission** recommended Canada start its own research so it would not have to

Jerome Jaffe

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Tobacco

Smokers of new low-tar, low-gas, low-nicotine cigarettes may be puffing their way into more trouble than if they had stuck to old-fashioned, high-everything brands, University of San Antonio's **Henry C. McGill** said (July '77) . . . The day when cigarette smoking is a thing of the past may not be far away. The same fate may befall liquor consumption — all because of growing social unacceptability, **Morris Chafetz**, former director of the United States National Institute on Alcohol Abuse and Alcoholism, said (July '77) . . . **Health and Welfare Canada** plans to warn

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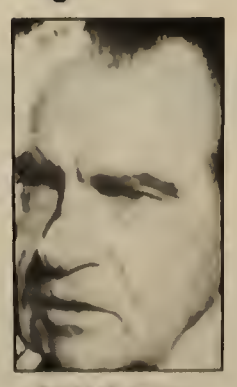
Money and Bureaucracy

Ending the confusion and divisiveness that hampered prevention of drug abuse in the United States is the major priority of the new **National Drug Abuse Council** (June '72) . . . **President Richard Nixon's** 1974 budget is seen as a clear signal that drug abuse remains high on the list of his domestic priorities (March '73) . . . . **Dr Jerome Jaffe** quit as director of the White House Special Action Office for Drug Abuse Prevention two years after he came on staff 'to knock heads' if that's what it took to coordinate the fight against drug addiction. His successor was **Dr Robert DuPont** (July '73) . . . . **Dean Roger O. Egeberg** of the University of Southern California medical school was named head of the new, and already turmoil-ridden, Alcohol, Drug Abuse and Mental Health Administration (Nov '73) . . . . In 1974, it cost **US taxpayers** more than $10 billion to fight drug abuse and heroin addiction (Feb '75) . . . . The Addiction Research Foundation must 'eradicate the weaknesses which so impair its competence.



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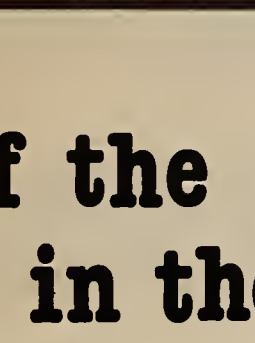
deaths and a new wave of heroin addiction (April '80). . . . **Phencyclidine** (PCP) intoxication in babies and very young children — often apparently caused by their being in the presence of PCP-smoking adults and teenagers — is a growing problem in Southern California (June '80). . . . A suggestion that **cancer and diazepam** (Valium) usage might be linked threatens to spark hot debate (Feb '81). . . . Canadian government plans to test theory that the popular **tranquillizer** diazepam encourages cancer growth (June '81). . . .


Nancy Reagan

They are smoking, shooting, or sniffing while parents stand by feeling confused and heartsick. We've come to realize there simply aren't any soft drugs — they're all dangerous and damaging, US First Lady **Nancy Reagan** said (Jan '82). . . . Heroin supplies will increase. There'll be more addicts and more overdose deaths. Crime rates will rise because addicts go out and commit crimes, **Supt Rod Stamler**, head of the RCMP Drug Enforcement Branch, warned (March '82). . . . A large and comprehensive study reveals a strong association between chronic sniffing of the solvent toluene and irreversible brain damage, **Addiction Research Foundation** scientists announced (May '82).

Cannabis

From what is now known about the effects of marijuana, its use at the present level does not constitute a major threat to public health, the United States National Commission on Marijuana told **President Richard Nixon** (June '72) . . . . Probably the most serious thing about cannabis is that it is being used by adolescents, the **LeDain Commission Report on Cannabis** found (June '72) . . . . Viewing cannabis as if it were a new pharmaceutical product, I could not agree to approval being given to the introduction, for general and repeated consumption, of a substance shown experimentally to be carcinogenic, teratogenic, and cumulative, and able to interfere with a variety of cellular processes until it had been shown quite unequivocally that, for some reason, humans were exempt from the actions concerned, Oxford University **Professor W.D.M. Paton** said (Aug '74) . . . If the decision is made to legalize cannabis, use of the drug will spread. If no compensatory reduction of insults to the health of the general public is made, there will be increased costs in those areas of social services that we now have, the health services particularly. And there is no more money. There'll have to be a decline of service — more than is already under way, Addiction Research Foundation scientist **Dr Eugene LeBlanc** said (Feb '76) . . . Marijuana lacks the lethal effects of either alcohol or tobacco, **Dr Robert DuPont**, director of the US National Institute on Drug Abuse, said (Feb '76) . . . Doubts about the wisdom of having supported decriminalization of marijuana are now haunting NIDA director **Dr Robert Dupont** (Aug '77) . . . .


Robert DuPont

The bill to liberalize Canada's marijuana laws has slipped into bureaucratic limbo once again (Feb '78) . . . 'Pot' has resurfaced as a hot political issue in Canada as the expected summer federal election approaches (April '78) . . . . I would say that every drug is potentially toxic material. Any drug which has a recognizable pharmacologic effect is capable of toxicity if given in high enough dosages over a long enough period of time. The question one wants an answer to, in order to qualify a drug as toxic or not, is how much is required to produce this effect and how many people are likely to use that much so as to experience those effects, **Dr Harold Kalant**, ARF director of biological studies, said (Oct '78) . . . . Two of my personal priorities are decriminalizing cannabis use, and taking a more aggressive 'lifestyle' advertising approach against alcohol and other drug abuse, Canadian Health and Welfare Minister **David Crombie** said (July '79) . . . . Canada's long-awaited marijuana reform is fading again and probably won't reappear until late 1980 at the earliest (Dec '79) . . . . Canada's Liberal government plans to table in Parliament the overdue cannabis reform legislation before the summer recess to give the public a chance to study the proposed changes before the bill is dealt with in the fall


Pat Erickson

(July '80) . . . . Prohibition has been a high-cost, low-benefit policy for controlling demand for cannabis, ARF criminologist **Patricia Erickson** said. The fact that cannabis possession is a criminal offence has no demonstrable effect on individuals' use of it (Nov '80) . . . . There are still more questions than answers about the long-term effects of marijuana on health, an international working group of physicians, psychiatrists, and medical scientists concluded in Toronto (May '81) . . . . A woman who smokes as few as five marijuana cigarettes a week during pregnancy can affect the functioning of the baby's central nervous system, a study by Carleton University's **Peter Fried** suggested (May '81) . . . . I don't think there's the slightest intention on the part of this government and frankly, I can't conceive of any government legalizing cannabis, **Alex Morrison**, head of the health protection branch of Health and Welfare Canada, said (July '81) . . . . Given the health hazards, does ARF advocate the use of cannabis? In a word, no. The risks to health are real. Some occasional users will suffer adverse consequences. High levels of use may severely damage health and sometimes cause death. There is strong reason to anticipate a high incidence of severe and life-threatening lung disease among regular users. There is the possibility of genetic mutations affecting future generations. These consequences are very serious for society. Therefore, on the evidence available, the ARF strongly advocates that cannabis not be used, ARF past president **Dr John B. Macdonald** said (Oct '81).

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. . . . A Japanese study found that non-smoking women married to smokers are twice as likely to die of lung cancer as those married to non-smokers (April '81) . . . Smoking kills and maims more women than cervical and breast cancers combined, yet the women's movement remains apparently unmoved, **Bobbie Jacobson**, author of *The Ladykillers* charged (Aug '81) . . . . Cigarette smoking is clearly identified as the chief preventable cause of death in our society, US Surgeon General **Everett Koop** said (April '82).


Everett Koop

ame director of the US National Inte on Alcohol Abuse and Alcoholism AAA), replacing founding director ris Chafetz who had resigned in the mer of '75 (Jan '76) . . . . The British mbia Social Credit government fired irman **Peter Stein** and the other five mbers of its Alcohol and Drug Comsion, then appointed provincial Narcs Addiction Foundation director **Bert kin** head of the commission (March '76) . **Dr John B. Macdonald** named new ARF f (April '76) . . . . **President Jimmy Car-**s administration will be receptive to g abuse problems, presidential advisor **Peter Bourne** said (Jan '77) . . . . Months r, **Dr Bourne**, a psychiatrist, resigned r it was revealed he wrote a prescription 15 methaqualone tablets for an aide. Dr rne used a pseudonym for the aide to protect her confidentiality, an explosive issue in psychiatric practice (Aug '78) . . . **Dr Edward Senay** of Chicago elected chairperson of a new grouping of US agencies named the National Alcohol and Drug Coalition — 80 (Nov '79) . . . . BC Alcohol and Drug Commission chairman **Bert Hoskin** resigned (May '80) . . . .


Joan Marshman

Research scientist **Dr Joan Marshman** replaced **Dr Macdonald** as third chief of the ARF (Feb '81) . . . . **President Ronald Reagan's** administration took office 'with no apparent transition or future White House drug policy.' Simultaneously, the president proposed to include alcohol and drug programs in block grant allocations to states and to slash grants by 20% in 1982, threatening disaster for many programs (March '81) . . . **David Archibald** created, almost single-handedly, a place where people could devote themselves to research, treatment, and public education of alcoholism and drug addiction — excerpt from a retirement tribute to the ARF founder (April '81) . . . . While US agencies waited for the federal axe to fall, a quieter fiscal drama began in Canada with the creation of a **Parliamentary task force** to examine what Ottawa could afford to spend on health, post-secondary education, and social services (June '81) . . . . NIAAA director **John DeLuca** resigned, protesting drastic 1982 budget cuts that crippled his association's research capabilities (Nov '81).


Peter Bourne/Jimmy Carter

'If there is one drug that is going to be the drug of the Seventies that we have to deal with, it is cocaine. And if there is one drug that I have a terrible problem with, it is cocaine.' Dr Peter Bourne, adviser to United States President Jimmy Carter (Aug '77).

1972 • 1982 The Journal

HOWELL ON HOWELL

For 10 years now, I have been churning out fantasies, allegories, parodies, satires, and other kinds of literary bric-a-brac to decorate the shelf the editors of **The Journal** *have so kindly provided for me.*

It occurred to me, as the 10th anniversary of **The Journal** *was approaching, that a decade of self-indulgence was enough. It was time that I got off my butt and did some honest reporting in the addictions field. And I would have too, had* **The Journal** *accepted my proposal.*

But **The Journal** *had no interest in an in-depth investigation of the drinking habits of people who take round-the-world cruises on luxury liners. Faced with this short-sightedness (I'm sure there is a story out there on the high seas waiting to be told) and such parsimony (my offer to go second-class instead of first didn't impress them at all), I had to envisage an investigative journalism project much more modest in scope.*

Unfortunately, **The Journal** *had no interest in the tequilla-drinking habits of North American tourists on the Mexican resort island of Cozumel either. And so I sadly unpacked my swimming trunks and my tape recorder and did the only thing I could do under the circumstances, I investigated myself. The transcript follows:*

Me: How did you get started in this business anyway?

Myself: A *Toronto Star* column of mine had been reprinted in *Addictions* magazine in 1971 and had resulted in quite a few requests for reprints from various publications in the field. I presume the request to write **The Journal** column came about as a result of that.

Me: Were you keen, delighted, flattered, or what?

Myself: Actually, I was quite reticent. I was not sure that I would be able to sustain a column for very long; I was not an alcohol and drug "insider," I didn't have a lot of personal axes to grind, and I was afraid that I would run out of material in a short period of time.

Me: There are some who would say that you did.

Myself: One more smart remark like that and the interview is over. Then you'll have to fill up this space on your own.

Me: I'm sorry. Please continue.

Myself: Anyway, I decided to take the chance and, well, here I am 10 years later, still at it.

Me: Were you given any guidelines at the outset?

Myself: I don't think anyone knew for sure what kind of column I would produce, and that included me. It was assumed that it would be "light" and/or "funny" but there were no specific guidelines. The first column I wrote took issue with a concept dear to the Addiction Research Foundation's (ARF) heart (the concept of controlling alcohol consumption through a pricing policy) and I fully expected to get some flak about it. But the column ran, I was given to understand that it was well received, and from that moment on I never felt I had to worry about a censorious hand. There have been two editors of **The Journal** in its 10 year existence. Both of them were supportive, and not once did I ever feel I couldn't say anything I wanted to, even if it conflicted with ARF policy, or made fun of it.

Me: Just what is it that you are trying to do with this column? Sometimes it is not too clear.

Myself: One thing I try to do is entertain. I respect people who work in the addictions field; it is not an easy field to work in, and the work can be demanding and frustrating, especially if one works in the front lines and has to deal daily with addicted people. If I can give those people a laugh, or a chuckle or two, I think I have accomplished something. I think it was Racine who said, "no small thing it is to sleep." I think that the same thing can be said about laughter. Paradoxically, the laugh I try to give people working in the addictions field is quite often at their own expense, for quite often it is their own profession, professional organizations, or manner of professional communication, that is being satirized.

Me: So the purpose of the column, I take it, is strictly to entertain.

Myself: No, that is an oversimplification. Even if I could write a genuinely funny column every month — one that would have them rolling in the aisles, so to speak — I'm not so sure that I would. Rightly or wrongly, I've always fancied myself a satirist rather than a comedian, and I prefer to write something that has a satirical bite to it. And when I can't do that, I provide whimsy, fantasy, and oddball little essays of one kind or another. All these things have their place: I like to think that my column in **The Journal** is the one thing that is completely unpredictable.

Me: I gather, then, that you think of your column as an ornamentation — bric-a-brac on the shelf, if you like. You don't appear to take it too seriously.

Myself: Well I don't take it seriously in the sense that I believe I have any special knowledge or wisdom to pass on. Lord knows, there are enough people like that in the addictions business already, we don't need another one. But I take the writing of the column seriously, and there are individual columns I look back upon with considerable pride.

Me: Are there any you regret?

Myself: Not to the point that I wish I had never written them. There are many I would do differently if I were to rewrite them today. In some ways, I regret that although from the outset I was given considerable freedom the columns have been a little too "soft." When I am writing in an allegorical mode I try to be as fair to all sides of an issue as I can be, and this often results in an ambivalent column with an enigmatic ending. Yet the best satire is often in really bad taste, and often throws fairness to the winds for the sake of making a point.

Me: You really feel this, that you haven't been mean enough?

Myself: Well generally, when you write satire, you intend to disturb people a bit. I feel, sometimes, that I haven't disturbed people as much as I should have.

Me: Maybe if you had you wouldn't have lasted 10 years.

Myself: That is precisely the point: my column is, perhaps, too comfortable.

Me: And so if you alienated your readers, then you'd be happy?

Myself: Definitely not. If I didn't think people were reading the stuff then what would be the point of producing it?

Me: I've always thought your columns were ambivalent. In the flesh you're even more so!

Myself: Now don't get impertinent. Who do you think you are, Mike Wallace?

Me: I would have been a terror on that cruise ship, let me tell you.

Myself: Well, I suppose Holland-American Line's loss is my gain.

Me: We were really getting somewhere until you scuttled sideways with that smart-ass Mike Wallace comment. That's what you do in your columns a lot you know — scuttle sideways with a lot of smoke and mirrors and verbal trickery. You don't get involved. You don't take positions. Except the shopworn liberal-left ones that are safe and easily defensible. You're always drifting off the point and resorting to cleverness of one sort or another. Take this column for instance. Supposedly it is a serious column, yet you felt compelled to introduce it with that nonsense about the round-the-world cruise, which is just a figment of your imagination.

Myself: Listen you miserable excuse for Woodward and Bernstein — you are just a figment of my imagination too. I can take over this column and finish it without you.

Me: Oh, aren't we being clever now. My, my, Pirandello lives and breathes, the Italo Calvino of the addictions crowd wants to wow us with a little surrealism, the better to avoid the[illegible]

Myself: Begone!

Me: I'm not going. That cute little business with the diagonal lines just illustrates my next point: you are more concerned with style than substance.

Myself: So what — I plead guilty to that. Many of my columns are pure stylistic froth and there is no substance at all, in the sense that the reader will learn any new facts. But in the addictions field there are people churning out facts daily (Marijuana use in Michigan schools down 10.5%; Alcohol use in recent Asian immigrants up 19.7%, etc, etc) and they are easy enough to obtain if you want them. **The Journal**, not incidentally, does a good job in providing them. And anyway, I subscribe to the heretical notion that, in a way, style can actually be substance.

Me: You've lost me there.

Myself: I look at addictions and the problem of how to solve them from different angles, some of which are, to say the least, rather obtuse. I think that there is some value or use — some substance if you like — in providing those different perspectives.

Me: I'm not so sure I follow you, or agree with you on that. You talk about different perspectives. But what I see, time and time again, is a kind of pervasive cynicism.

Myself: There is certainly some truth to that, but it is difficult to avoid. I once wrote a column about therapeutic communities and what was going to happen to them in the future; I described how they would become bureaucratized, rigid, and stodgy. Not long afterwards, I got a long-distance telephone call from a person who had recently been employed in a therapeutic community. This person said I had described the situation in his community exactly and wondered what therapeutic community I had worked in. When I hung up the telephone, I felt rather sad. Because, you see, I had just ascribed the worst of human motives to people running therapeutic communities, and written the column on that basis — I had never been near a therapeutic community in my life. It saddened me to think that my cynical prognostications about human behavior, which had actually been made in a tongue-in-cheek manner, were no more than an accurate description of behavior that was actually going on.

Me: It's interesting to hear you talk about feelings. Because if your column is one thing, it is impersonal. You almost never write out of personal experience.

Myself: That is true, and I take some pride in that fact. It is egocentric enough that I expect the reader to read, what is, in essence, more a product of cleverness than cogitation; if I were to get personal I am sure I would become as insufferable as some stream-of-consciousness lay newspaper columnists I gave up reading years ago. This particular column is quite personal, and frankly I'm a little uncomfortable with it, but I don't think it's any great sin to indulge in this kind of thing once every 10 years.

Me: I don't think your column is as "funny" as it used to be. Is that by design or by default.

Myself: During the past few years, I've taken more chances with the column; I've tried to avoid formula situations, and I've worked harder on creating a particular mood, or atmosphere. I think I'm writing better now than before but that does not mean that readers will necessarily enjoy what I write more, or even think it as relevant as it used to be.

Me: I don't quite understand that. If you are, as you say, writing "better," why would not readers appreciate it more?

Myself: Because this whole business is so subjective. A column either works for a reader or it doesn't. Let's face it, a lot of them are little more than juggling acts, and sometimes the reader can honestly feel that I failed to keep all the balls in the air. I tend to like columns where I have dared a lot, and I persist in liking them even though I perhaps dared too much from the point of view of approach or style — I asked the reader to suspend too much disbelief, or invited him or her to share a particular literary conceit that for one reason or another he just could not share. In other words, readers like columns that succeed, and I like the ones that I consider, in retrospect, honorable failures. That's probably the way it should be. I just hope that I succeed often enough that the regular reader of **The Journal** will always at least give my column a try.

Me: Do you think I'll be interviewing you in another 10 years?

Myself: Anything is possible. The first 10 years have certainly been fun for me. I hope they have been for the reader, too.

An Essay

By Richard Gilbert

1972 • 1982 The Journal

DRUG ABUSE IN 1992

A 10th anniversary is a time for looking back with wonder at how things hung together for so long, and for looking forward with fear that we shall see them flying apart.

Albert Einstein once claimed not to think of the future. "It comes soon enough," he said. More often he revealed a desperate concern: ". . . the unleashed power of the atom has changed everything except our modes of thinking, and we thus drift toward unparalleled catastrophes."

Bombs

Today's nuclear weapons have in aggregate one million times the explosive power of the bomb that was detonated over Hiroshima — a bomb that destroyed a city of 340,000 people and killed or maimed most of its inhabitants. The burden of weaponry poised to annihilate us all grows daily.

Unless people around the earth stop making nuclear weapons, and dismantle what they already have, Einstein's unparalleled catastrophes will happen. The human species will extinguish itself.

A limited exchange is unlikely. Why should a leader's rationality be enhanced by the knowledge that a few million fellow citizens have been obliterated, and a few million more are battered and burnt, sick and sterilized from massive radiation, and writhing in unthinkable agony? Why should such a leader say enough is enough? Vengeance and retaliation would be more likely, even if the initial strike was known to be accidental. Once the first bomb has been dropped, the rest will follow. And, if the operators die before the job is done, robust computers will finish the work.

We live in the shadow of annihilation that could occur without warning. If it is not today, it may be tomorrow — or the next day. Even if no decision is made to use nuclear weapons, they may fall anyway, set in motion by a quirky circuit board. As stockpiles grow, so does the chance of an accident. The dice are thrown daily, and our number may very well come up before 1992.

Thus, when we think of life a decade hence, or even the small part of life that is drug abuse, we must first wonder whether there will be life at all.

We must also wonder at the effect that the growing knowledge of the possibility of the imminent cancellation of life might have on behavior. Will people grow desperate and drink more? Will caution about the hazards of smoking be thrown to the winds, because there will be no future in which to be regretful? And what of the effect of a determined effort to purge ourselves of our plight? Would drug use diminish if we were to bend ourselves to our own salvation?

Computers

If we set aside the bomb, and its awful foreboding, and think of other great forces that might shape our society in the next decade, we must dwell on the computer; not only the computers that guide the weapons that are targeted on our homes, and the homes of people in other parts of the world, but also the computers that are coming into our homes and into our places of work.

Few things seem as powerful in their ability to capture the interest and devotion of a young mind as an interactive computer. As computers flood into homes during the next decade, much as television sets did two and three decades ago, children will be touched profoundly. Brought up on BASIC, they will have the edge in a computer age. In important respects, 12-year-olds will be more able to cope than their computer-illiterate parents. Adolescents, whose rebelliousness seems to be a critical factor in the formation of attitudes toward drugs and in the use of drugs, will no longer be striving for power and control. They will have already experienced power and control through their early intimacy with our society's new organizing principle.

Meanwhile, large parts of earlier generations will be being displaced at work by other waves of the same flood. As the literate revel in their accomplishment, the illiterate will feel more and more out of touch and, quite possibly, out of work, displaced not only because of their ignorance but also because there will be fewer things for humans to do.

If the literate are compassionate, the displaced illiterate will have the means to survive in some comfort, but these will also be the means to escape from their plight, perhaps into alcoholic or other kinds of oblivion.

Seeing the future of drug abuse only in terms of the bomb and the computer may be thought a little too etherial. So I ventured to put my speculation on a solid footing by consulting half a dozen senior researchers and clinicians at the Addiction Research Foundation (ARF) as to their views of the next decade: how patterns of drug use and abuse will change; how society's responses to drug abuse will be different; what developments in research and treatment will be made; how the drug abuse industry will fare; and so on.

All were willing respondents. Most thought for a while, began by discounting the value of such prediction, and then unleashed a torrent of comment about how the drug scene will change. Thinking about the next decade was an adventure. What follows is a summary of these views, sometimes embellished by my own interpretations.

Finances and fads

In terms of broad societal impacts on the drug abuse scene, the main preoccupation was not bombs or computers but the economy. Gloom prevailed. Recession will reduce alcohol and tobacco use, and, less obviously, the use of other drugs. Even though declining material prosperity may give people more reasons to use drugs, actual consumption will be restrained by how much can be afforded, which will be less.

Reduced drug use in the next decade will make the drug abuse prevention industry, of which the ARF is a part, less successful in securing a share of society's resources. Also, the purse being shared will be smaller, because governments will have less to give. Thus the future for this business is bleak. The ARF will dwindle, but not disappear.

The economy will be the major but not the only actor in the drug abuse field, said many of my respondents. Fads will be an important factor, as ever. Just as cocaine has waxed and waned and waxed again in the last century, so might absinthe stage a revival. Tobacco is certainly on the way out, as much because it is becoming unfashionable to smoke as because it is unhealthy. By 1992, cigarette smoking will be a private activity, as marijuana use is now, although cigarette use will still be legal. Alcohol use will continue, down a little because we will be poor, but maintaining its role in our culture, or even expanding into the public domain, its acceptance buttressed by news that moderate use might be medically beneficial. Moves to moderate use and reduced consumption might show themselves most in lower concentrations of alcohol in standard drinks. Beer at 3.5%, wine at 9%, and liquor with lots of mixer will be the norms.

I was told that the changing age distribution of the population will be a factor leading to reduced drug use. As the average age increases, illicit drug use will decline, because older people seem more inclined to follow the law. The redoubtable United States National Institute on Drug Abuse has published a whole monograph (No 35: May, 1981) devoted to a part of this maxim. Louise G. Richards painstakingly predicted what will be drug use by people in the US aged 18 to 25 years in 1985, in 1990, and in 1995 by estimating populations for these years and assuming that the prevalences of use of the various drugs would be the same as they were by 18- to 25-year-olds in 1977. Using this method Dr Richards described how there might be changes in the use by young people of marijuana, inhalants, hallucinogens, cocaine, heroin, and other opiates. She concluded:

"While the number of adult drug abusers, overall, may decline in the next decade, it is difficult to estimate with any precision the shape of the drug abuse problem among this group. If earlier trends continue to repeat themselves, the following patterns of drug use may emerge:

- *Regular use of marijuana will be on the upswing but the percentage of occasional users should stabilize.*
- *Use of hallucinogens should not change dramatically.*
- *The percentage of cocaine users, particularly occasional users, will increase over the next decade.*
- *The percentage of young adults using heroin and other opiates should not change dramatically."*

All this is set out in fine detail in 43 tables and two appendices.

Discoveries

Apart from caffeine, whose use will depend on the politics of South America, India, and Sri Lanka, alcohol will be the only popular drug. But a great variety of other drugs will be available, selected as from a cafeteria by users sophisticated in pharmacology. Drugs will be chosen to match moods and to achieve particular states, perhaps a different one each evening. Clinicians will be faced with the consequences of unfathomable interactions between compounds whose basic features are barely comprehended.

A new feature of substance use will be the supplementation of endogenous body chemicals. People will come to take endorphins and other such compounds in order to achieve particular moods and sensations. Other means (electrical, sonar, behavioral?) will be found to stimulate production in the body of desired chemicals, and thus we will have the possibility of substance abuse without anything being consumed or injected.

Other discoveries will include the marijuanalyser, which may pave the way for legalization of the drug by enabling regulation of 'high' driving. Genetic aspects of proneness to alcohol abuse will become thoroughly understood, as will the ways in which alcohol acts as a reinforcer. But these discoveries, and similar ones for other drugs, will bring us no nearer to a unified explanation of drug abuse. Pharmacologists will develop more drugs like methadone, drugs that unprovoke desire, but do not take away from performance.

Research, said my respondents, will benefit diagnosis and treatment in many ways. It will provide biochemical batteries that give precise accounts of the extent and intensity of drug use. Enthusiastic social drinking will not escape detection during the annual check-up. But treatment for the drinking will be sought not so much in the doctor's office or medical clinic as in well-marketed, self-help courses that exploit refinements in behavioral technology.

Cures

Unwilling drinkers and users of other drugs will be able to buy a memory diskette at their local software store and use their home computer to work through a regimen that leads to abstinence or controlled light use, as the case may be. The computer will monitor drug taking, perhaps remotely, provide advice, encouragement, and information about progress, and utter dire warnings or even threats when necessary ("no games tonight, Henry, if you down one more drop"). Not only might computers drive people to drink, they might also cure them of the compulsion. Bombs will provide no such blessing.

With or without computers, people will be expecting to cure themselves of their behavioral disturbances, including drug abuse. The medical profession's hegemony in this area will be a thing of the distant past, as it is now in the case of obesity. Physicians will fight back because drug abusers will still provide a lucrative market, but their involvement will be rarer, because they are pricing themselves out of business.

The move to do-it-yourself medicine will be encouraged by government, who will recognize the relief it provides to health-care budgets. Less expensive, and even revenue-producing, steps will be taken to curb consumption, including drug education in schools, and tax hikes that produce increases in real price.

Edmund Burke said that you can never plan the future by the past. He overlooked the obvious — that we have little else to go on. What is remarkable about the drug scene in Canada in 1982 is how similar it is to that of 1972. A projection of apparent trends at that time a decade forward would have suggested much heavier use today of almost every item except tobacco. A decade of relative stability may have lulled us into believing that little change is likely during the next 10 years. This would be foolish in my view. Human behavior remains as unpredictable as ever. Big changes in our society are well under way in the role of computers, in the economy, and — I should have mentioned it earlier — in relations between women and men. Drug abuse will be a part of this swirl. If we can all survive another decade, which seems doubtful today, working in this field will still be an exciting thing to do — if you can stay employed.

NEWS AND LETTERS

Canadians featured speakers at CPDD

TORONTO — The Canadian approach to problems of drug dependence will be a major component of scientific discussions to be held here this month as part of the 44th annual meeting of the (United States) Committee on Problems of Drug Dependence Inc.

The meeting, June 27 through 30, will feature Canadian speakers Dr Joan Marshman, president of the Addiction Research Foundation of Ontario (ARF); Dr Ian Henderson, director, bureau of human prescription drugs, health protection branch, Health and Welfare, Canada; and Dr Juan Negrete, department of psychiatry, Montreal General Hospital.

Five US speakers will address the subject "Advances in Drug Abuse Treatment," and shorter, simultaneous sessions will include approximately 50 papers reporting on work in biomedical, clinical, and treatment studies in the field of drug dependence. The Committee consists of 15 members, including Dr Harold Kalant of the ARF, and has a board of directors made up of representatives of nine major organizations.

The committee has been active in formulation of US policy and serves as an adviser to the US Food and Drug Administration and the US Drug Enforcement Administration.

For additional information, contact: Dr Joseph Cochin, department of pharmacology, Boston University School of Medicine, 80 East Concord St, Boston, Massachusetts 02118.

Letters to the Editor

Drug-induced creations 'never more than doggerel'

(from page 6)

out: "It is not at all rare for drug addicts to claim that during a trance or a trip they have effortlessly written a long and marvellous poem or story. The poem or story, if any attempt is made to commit it to paper, proves to be no more than a few garbled lines of jabberwocky. Instances of Coleridge's verse written under the influence of drugs or alcohol, or both, are scattered throughout the notebooks. They are never more than doggerel."

On the other hand, Coleridge *was* addicted to laudanum (a tincture of opium: Ed) at the time he composed *The Rime Of The Ancient Mariner*.

It appears to be a perennial romantic fancy that drugs can enhance creativity, and Coleridge was part of that kind of public posturing. Privately, he wrote more frankly about his bondage to opium — indications are he felt the monkey on his back as keenly as ever a mariner felt an albatross around his neck.

De Quincy remains the last word on drugs and creativity: "If a man whose talk is of oxen should become an opium eater, the probability is that (if he is not too dull to dream at all) — he will dream about oxen . . ."

Mark Worden, Associate Editor
Alcoholism,
The National Magazine
Seattle, Washington

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Susan Reid, coordinator of the group, at (416) 595-6150.

The Young Alcoholics

Number: 499.
Subject Heading: Youth and alcohol.
Details: 20 mins; 16 mm; color.
Synopsis: The film opens with a series of scenes depicting young people obtaining and/or using alcohol surreptiously. A young, former alcoholic, recounts her experiences to a class of teenagers, and discusses the influences which encouraged her to begin drinking, as well as her decision to quit. Tom Alibrandi discusses his experiences counselling young people with alcohol problems, and presents statistics on the problem of teenage alcoholism. A teen-counselling group is depicted, and agencies where young people can get help are discussed. The film ends with the assertion that the "disease of alcoholism is the third largest killer in society," and only "one person in 36 finds help".
General Evaluation: Poor (1.9). Although this film was judged to be of appropriate length for most educational settings, the group said it was an inappropriate teaching aid due to its questionable information regarding the extent of use of alcohol by young people. This boring and unrealistic film appeared to be staged, leading the group to judge it to be poorly-produced, and lacking emotional impact.
Recommended Use: Although the film is intended for teenage audiences (aged 12 to 18 years), the group rated it as neither harmful nor beneficial to this or any other audience. If used, the presence of a resource person is essential.

Hey, Do I Need A Cigarette

Number: 504.
Subject Heading: Smoking.
Details: 12 mins; 16 mm; color.
Synopsis: This animated film follows a man through a series of events related to his smoking habit. While he is getting cigarettes out of a machine, he is shocked to meet a young boy who is "having a nicotine fit." The man falls down a manhole and when he lights a cigarette, the sewer pipe lectures him on the hazards of smoking. He is arrested by a police officer who notices him loitering about in the streets. He pleads his case in court where the judge gives him a choice of two dispositions: "cold turkey," or "tapering off slowly." Meeting up with the young boy again, he is told about the boy's parents health problems caused from smoking. The young boy and the man decide to take the judge's advice and "kick the habit (cold turkey) together".
General Evaluation: Fair (2.8). A great deal of information was presented in a length appropriate for most educational settings. However, the film was judged to be boring and unrealistic, lacking emotional impact, and utilizing outdated production techniques. Despite these ratings, some members of the group felt the film might help in decision-making regarding smoking.
Recommended Use: This film seems to be intended for adult audience, but was judged to be neither harmful nor beneficial to this or any other audience.

DEPARTMENT

New Books by RON HALL

Female Addiction: A Longitudinal Study

. . . by Walter R. Cuskey and Richard B. Wathey

The information presented has significance for people in the health-science field. The book provides information about the needs and problems of female addicts and their children, and methods of treating this population. It documents and evaluates work accomplished in an innovative treatment program, and provides findings of use to clinicians and researchers working in the health field. Some treatment agencies have considered drug abuse and alcoholism to be primarily male problems, and most of the early drug treatment models were designed for, and by, men. In some cases, service providers have not taken into account the fundamental ways in which the needs of women differ from those of men. Chapters one through five survey the literature dealing with female drug addiction, with special emphasis on the seriousness of the problems of female addiction and information concerning its processes and implications compared to available data on male addiction. Following a description of Odyssey House and the Mabon Parents' Demonstration Project in chapter six, chapters seven and eight explore the histories of drug users and their families, noting differences between white and non-white subjects. Chapter nine makes some tentative recommendations concerning treatment models, based on the three models traditionally offered in the literature. Behavioral and psychological changes in treatment are covered in chapters nine and 10, with particular attention to racial differences and addicts' profiles at various stages of treatment.

(D.C. Heath Canada, Suite 1,600, 100 Adelaide Street West, Toronto, Ontario M5H 1S9, 1982. 168p. $27.50. ISBN 0-669-05029-0)

Other Books

Drugs and the Whole Person — Duncan, David, and Gold, Robert. John Wiley and Sons, New York, 1982. Who takes drug and why: how drugs work on the mind: herbal drugs: over-the-counter drugs: tobacco: alcohol: illicit drugs: opiates, cocaine, marijuana, psychedelics: drugs and law: primary prevention of drug abuse: drug education: treatment and rehabilitation: responsibilities of the recreational drug user. Bibliography, glossary, index. 260p. $15.50.

Drugs of Choice: Current Perspectives on Drug Use — Schlaadt, Richard G., and Shannon, Peter T. Prentice-Hall, Englewood Cliffs, 1982. Perspective on drugs: why people use drugs: the drug scene: pharmacology: stimulants: tobacco: depressants: alcohol: opiates: hallucinogens: marijuana: over-the-counter drugs: other drugs of interest: the consumer and drug legislation: alternatives to psychoactive drug abuse. Index. 303p.

Clinical Use of Drugs in Patients with Kidney and Liver Disease — Anderson, Robert J., and Schrier, Robert W. (eds). W. B. Saunders Company, Philadelphia, 1981. Clinical pharmacology: adverse drug reactions: clinical use of drug assays: drug-induced chronic renal failure: drug-induced fluid and electrolyte disorders: drug-induced cholestatis: drugs in patients with liver disease. Appendix, index. 348p.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Ethnocultural Issues in Psychotherapy — June 12, Toronto, Ontario. Information: Ms E. Essue, conference secretary, Clarke Institute of Psychiatry, 250 College Street, Toronto, ON M5T 1R8.

CODA Drug Abuse Seminar — June 17, Toronto, Ontario. Information: M.A. Harrison, CODA, 56 Esplanade Street E, Suite 303, Toronto, ON M5E 1A7.

Summer School on Addictions — June 20-25, Charlottetown, Prince Edward Island. Information: The department of extensions and summer sessions, University of Prince Edward Island, Charlottetown, PEI CIA 4P3.

30th Biennial Conference on Social Development — June 21-23, Montreal, Quebec. Information: Jean-Claude Patenaude and Associés Ltée, Public Relations Consultants, 3446, rue St-Denis — Bureau 101, Montreal, Quebec H2X 3L3

73rd Annual Conference Canadian Public Health Association — June 21-24, Yellowknife, Northwest Territories. Information: Gerald H. Dafoe, executive director, Canadian Public Health Association, 1335 Carling Avenue, Suite 210, Ottawa ON K1Z 8N8.

Canadian Paediatric Society Annual Meeting — June 26-30, London, Ontario. Information: Canadian Paediatric Society, Centre Hospitalier Universitaire De Sherbrooke, Sherbrooke, Quebec.

The Northern Symposium on Addictions — June 26-30, Yellowknife, Northwest Territories. Information: Canadian Addictions Foundation, 251 Laurier West, Suite 1100, Ottawa, Ontario KIP 5R6.

Committee on Problems of Drug Dependence, Inc — June 27-30, Toronto, Ontario. Information: Dr Joseph Cochin, department of pharmacology, Boston University School of Medicine, 80 East Concord Street, Boston, Massachusetts 02I18.

23rd Institute on Addiction Studies — July 18-23, Hamilton, Ontario. Information: Karl N. Burden, course director, Alcohol and Drug Concerns, I5 Gervais Drive, Suite 603, Don Mills ON M3C 1Y8.

Summer Course in Addictions — July I9-23, Toronto, Ontario. Information: School for Addiction Studies, 8 May Street, Toronto, ON M4W 2Y1.

Workshop on Evaluation Research in the Field of Addictions — Sept 8-9, Regina, Saskatchewan. Information: Brian Rush, Addiction Research Foundation, Research Centre for Regional Programs, University of Western Ontario, London, ON N6A 3K7.

Early Recognition and Management of Health Problems in the Workplace — Sept 27, Oct 28, Nov 25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Road, Toronto, ON M4G 3Z1.

American Society of Criminology — Nov 4-6, Toronto, Ontario. Information: Harvey C. Horowitz and Associates, 10369 Currycomb Court, Columbia, Maryland 21044.

The Management of Employee Assistance Programs — Feb 23-25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Road, Toronto, ON M4G 3Z1.

5th World Conference on Smoking and Health — July 10-15, 1983, Winnipeg, Manitoba. Information: Fifth World Conference on Smoking and Health, PO Box 228, Station B, Ottawa, Ontario.

United States

The 17th Annual Association of Halfway House Alcoholism Programs of North America, Inc (AHHAP) — June 6-11, Anchorage, Alaska. Information: Harold D. Angell, Association of Halfway House Alcoholism Programs of North America, Inc, 786 E Seventh St, St Paul, Minnesota 55106.

3rd Annual National Conference on Employee Assistance Programming — June 7-10, Kansas City, Kansas. Information: EAP Conference Center, Bethany Medical Center, 51 N 12th St, Kansas City, KS 66102.

Drug Information Association 18th Annual Meeting — June 13-16, Kansas City, Missouri. Information: Drug Information Association, PO Box 113, Maple Glen, PA 19002.

8th Annual Colorado Summer School of Alcohol Studies — June 13-18, Colorado Springs, Colorado. Information: Don R. Dehon, Alcoholism Council of Colorado, 2525 West Alameda, Suite 219, Denver, CO 80219.

Workshop on Chemical Dependency and Adolescents — June 13-18, July 11-16, Minneapolis, Minnesota. Information: Mary Simonson, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN 55441-6199.

University of Utah School on Alcoholism and Other Drug Dependencies — June 20-25, Salt Lake City, Utah. Information: University of Utah School On Alcoholism and Other Drug Dependencies — PO Box 2604, Salt Lake City, UT 84110.

The Mid-South Summer School on Alcohol and Drug Problems — Prevention and Treatment — June 20-25, Fayetteville, Arkansas. Information: Gwen Briscoe, GSSW-UALR, Little Rock, AR 72204.

Summer School of Alcohol Studies — June 20-July 9, New Brunswick, New Jersey. Information: Claire Osman, American Medical Society on Alcoholism, 733 - 3rd Avenue, New York, NY 10017.

Basic Workshop on Chemical Dependency and the Family — June 2I-25, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN 55441-6I99.

33rd Annual Symposium on Alcoholism — June 21-July 2, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, I2th & E Columbia, Seattle, WA 98122.

Sexuality for Alcoholism Counselors — June 22-July 13, Seattle, Washington. Information: Alcohol Studies Program, Seattle Washington, 12th & E Eolumbia, Seattle, WA 98122.

Coping In The 80s — An Institute for Educators on Drug and Alcohol Abuse, Sexuality, Communication and Counseling Skills — June 28-30, Kingston, Pennsylvania. Information: Charles Lull, Dean of Students, Wyoming Seminary, College Preparatory School, Kingston, PA 18704.

5th Annual Convention of the National Association of Prevention Professionals — June 28-July 2, Santa Fe, New Mexico. Information: Karen Edens, NAP President, 650 Cedar St, Centennial Building, St Paul, Minnesota, 55155.

6th National Youth Workers Conference — July 5-8, Washington, DC. Information: National Youth Workers Alliance, 1346 Connecticut Ave, NW, Washington, DC 20036.

11th Annual San Diego Summer Alcohol and Drug Studies Program — July 11-16, San Diego, California. Information: Elizabeth Hendrickson, UCSD Extension, X-001, La Jolla, CA 92093.

Group Seminar on Adolescence and Chemical Abuse — July 19-23, Minneapolis, Minnesota. Information: Mary Simonson, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN 55441-6199.

The 14th Annual Nevada Substance Abuse School — July 19-23, Reno, Nevada. Information: Angela L. Alaimo, bureau of Alcohol and Drug Abuse, 5th Floor Kinkead Building, 505 E King Street, Room 500, Carson City, NV 89710.

Support Group Facilitator Training Workshop — July 26-30, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN 55441-6199.

Annual Meeting of International Doctors in Alcoholics Anonymous — July 29-August 1, Des Plaines, Illinois. Information: Lewis K. Reed, MD, Information Secretary, IDAA, 1950 Volney Road, Youngstown, Ohio 44311.

7th Annual New Jersey Summer School of Alcohol and Drug Abuse Studies — Aug 1-6, New Brunswick, New Jersey. Information: Ronald L. Lester, director, New Jersey Summer School of Alcohol and Drug Abuse Studies, Rutgers University, Smithers Hall, New Brunswick, NJ 08903.

Project Charlie, a Drug Abuse Prevention Program — Training Workshop — Aug 9-13, Edina, Minnesota. Information: Project Charlie, 570I Normandale Road, Edina, MN 55424.

The National Association of Alcoholism Counselors Annual Meeting — Aug 15-18, Long Beach, California. Information: NAAC, 951 S George Mason Drive, Arlington, Virginia 22204.

Alcohol and Drug Problems Association Annual Meeting — Aug 29-Sept 1, Washington, DC. Information: Alcohol and Drug Problems Association, 1101 15th St, #204, Washington, DC 20005.

6th Annual Summer Institute of Drug Dependence — Aug 29-Sept 3, Colorado Springs, Colorado. Information: The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 89091.

Alcoholism Treatment: Cooperation or Competition — Sept 20-22, La Jolla, California. Information: Naomi Feldman, Conference Coordinator, 3770 Tansy, San Diego, CA 92121.

5th National Impaired Physician's Conference — Sept 22-25, Portland, Oregon. Information: AMA, department of mental health, 535 N Dearborn, Chicago, IL 60610.

Evaluating Alcohol and Drug Programs: Current Methods and Findings — Sept 13-17, Brooklyn Park, Minnesota. Information: Leslie Nyberg, evaluation and research department, Box 11, Center City, MN 55012.

The Benzodiazepines Today: Two Decades of Research and Clinical Experience — Oct 9-10, San Francisco, California. Information: Stephanie Ross, Haight Ashbury Training and Education Project, 409 Clayton Street, San Francisco, CA 94117.

Annual Postgraduate Course in Clinical Pharmacology, Drug Development and Regulation: 1982 — Oct 25-29, Rochester, New York. Information: William M. Wardell, The University of Rochester Medical Center, department of pharmacology and toxicology, 601 Elmwood Avenue, Rochester, NY 14642.

11th Annual Meeting of the Association of Labor Management Administrators and Consultants on Alcoholism (ALMACA) — Nov 2-5, Philadelphia, PA. Information: ALMACA, 1800 N Kent St, Suite 907, Arlington, Virginia 22209.

Alcoholism: Culture and Treatment: Comparative Perspectives from Europe and America — Nov 4-6, Farmington, Connecticut. Information: Margie Meadows, Administrative Assistant, department of psychiatry, University of Connecticut Health Center, Farmington, CT 06032.

Women In Crisis, Inc, 4th Annual Conference — Nov 10-13, New York, New York. Information: Women In Crisis, Inc, 37 Union Square West, New York, NY 10001.

7th World Conference of Therapeutic Communities — May 8-13, 1983, Chicago, Illinois. Information: Donna Gleixner, Gateway Houses Foundation, Inc, 624 S Michigan Avenue, Chicago, IL 60605.

Scholarly Communication Around The World — The 27th Annual Conference of the Council of Biology Editors, the 3rd International Conference of Scientific Editors, and The 5th Annual Meeting of the Society for Scholarly Publishing — May I5-20, 1983, Philadelphia, Pennsylvania. Information: I983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Service, 2I00 Arch Street, Philadelphia, PA 19103.

Abroad

13th Collegium Internationale Neuro - Psychopharmacologicum Congress — June 20-25, 1982, Jerusalem, Israel. Information: Secretariat, 13th CINP Congress, POB 29784, Tel Aviv, Israel.

28th International Institute on the Prevention and Treatment of Alcoholism — July 4-I0, Munich, Fed Rep of Germany. Information: Wagons-Lits Tourisme, Case postale 1003, 1001 Lausanne, Switzerland.

Working With Problem Drinkers In The Family — July 5-7, Manchester, England. Information: Ms Jane Stott, Course Coordinator, Alcohol Education Centre, 99 Denmark Hill, The Maudsley Hospital, London, England SE5 8AZ.

28th International Institute on the Prevention and Treatment of Alcoholism — July 5-9, 1982, Munich, Fed Rep of Germany. Information: International Council on Alcohol and Addictions, Case postale 140, Ch — 1001, Lausanne, Switzerland.

1st Congress of the International Society for Biomedical Research on Alcoholism — July 6-10, Munich, Fed Rep of Germany. Information: Ronald G. Thurman, department of pharmacology, School of Medicine, 1124 Faculty Laboratory Office Building, University of North Carolina at Chapel Hill, NC 27514.

2nd Biennial AU School of Justice Institute on Juvenile Justice — July 11-30, London, England. Information: Dean Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

1982 Summer School on Alcohol Problems — Aug 14-20, York, England. Information: Jane Stott, course coordinator, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London SE5 8AZ.

11th International Conference on Health Education — Aug 15-20, Hobart, Tasmania, Australia. Information: Joy Faldt, Australian Society of Health Educators, PO Box 818, Fortitude Valley, Queensland, Australia 4006.

Working With Problem Drinkers — Aug 23-27, York, England. Information: Ms Jane Stott, course coordinator, Alcohol Education Centre, 99 Denmark Hill, The Maudsley Hospital, London SE5 8AZ.

4th World Congress for the Prevention of Alcohol Problems, Alcoholism and Drug Dependency — Aut 29-Sept 2, Nairobi, Kenya. Information: ICPA — International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St NW, Washington, DC 20012.

33rd International Congress on Alcoholism and Drug Dependence — Oct 9-15, Tangier, Morocco. Information: Archer Tongue, ICAA, Case postale I40, 1001 Lausanne, Switzerland.

Influence of Environment on Man — Nov 17-20, Vienna, Austria. Information: Secretariat Brussels, rue E Bouillot 61 Box 11, B-1060 Brussels, Belgium.

The Journal

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Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
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Circulation: 15,094

(Ontario, 11,580, other provinces, 815, USA, 1,979, foreign, 720). Bulk, 3,700, Media, 1,273

Single Subscription Rates
Ontario Residents free
Other Canadian Residents $12 per year
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ISSN 0044-6203 Printed in Canada

What price tranquillity?

By Betty Lou Lee

TORONTO — A horror movie of a different genre is currently in circulation, and the thing of which its nightmares are made is Valium.

I'm Dancing As Fast As I Can, based on the autobiography of television-producer Barbara Gordon, chronicles her fight to overcome dependence on North America's most-prescribed drug.

With less melodrama, but no less chilling effect, two Canadian women have compiled a book that chronicles the impact the group of tranquillizers that includes Valium is having: not only on individual users, but society as a whole.

The Effects of Tranquillization: Benzodiazepine Use in Canada,* is the work of medical sociologist Ruth Cooperstock, a scientist in social policy and epidemiology at Ontario's Addiction Research Foundation, and Jessica Hill, a social worker, and Ontario regional director for the health promotion directorate, Health and Welfare Canada.

The authors review more than 100 studies, reports, and articles, many of them published in the last five years. In keeping with their purpose and the book's title, they concentrate on the Canadian literature, but reinforce it with significant United States and European findings.

They document the pervasiveness of these drugs that have proliferated from the original, Librium, in 1960, to 10 benzodiazepines sold as more than 40 different products two decades later. The drugs are marketed as anti-anxiolytics, muscle relaxants, hypnotics, and anti-convulsants.

A recurrent theme is the widespread, long-term use of prescribed benzodiazepines.

"There are a variety of positive functions . . . in short-term use for control of acute anxiety, neuromuscular disorders, and as an anti-convulsant. Efficacy as an anti-anxiety agent has not been demonstrated for longer than a few weeks, and, because of the risk of dependency, as well as with the individual variation in dose response, continuous use should not exceed two weeks," the authors caution.

Yet in Saskatchewan, 20% of those taking mood-modifiers had received more than five prescriptions a year, with each prescription giving at least one month's supply. In the United States, 33% to 85% of users had been taking them for more than two months. In Britain, more than half of psychotropic users had been on them more than a year, and one-quarter more than two years.

(One of the many shortcomings in existing data is the varying terms in studies. Some lump together all psychotropics or mood-altering drugs. But, the authors point out, the minor tranquillizers, and benzodiazepines specifically, make up the largest groups in these classifications.)

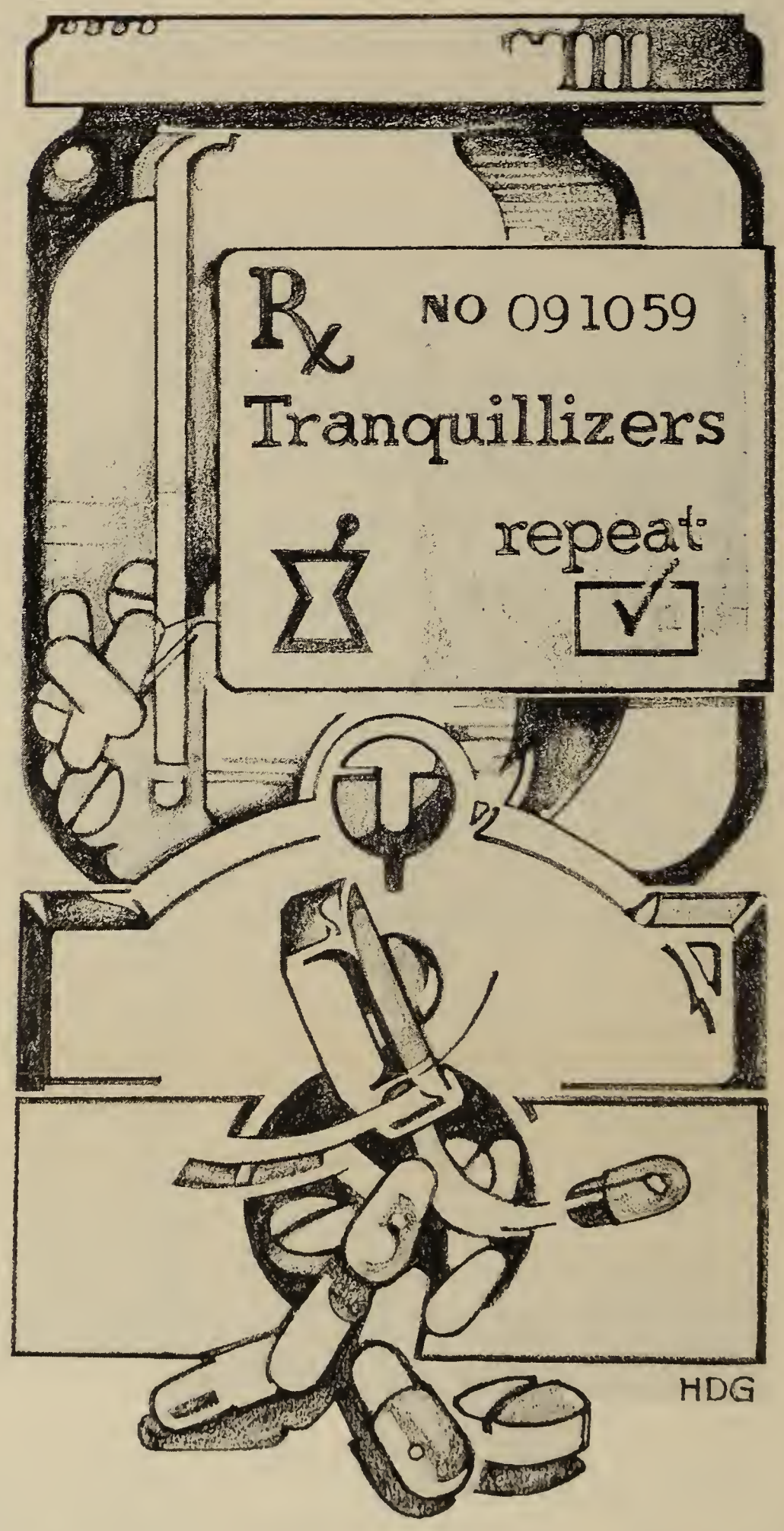
One study of patients on low doses for a mean of 3.6 years found that 27% to 45% had withdrawal symptoms. Evidence that these symptoms are not those of the pre-existing condition for which the drug was prescribed includes the fact that babies born to benzodiazepine-dependent women may show withdrawal symptoms.

Intentional overdosing is common. Canadian poison control centres reported a 46% increase in Valium poisonings between 1970 and 1976, and the patients were mostly adults — not children who took it accidentally.

There are no reported deaths from overdoses of benzodiazepines alone, but they can be deadly when used with alcohol and other drugs.

Polydrug use is widespread, particularly with alcohol, and can potentiate or reduce the effects of the tranquillizers. Smokers, for example, may need 50% more benzodiazepine for the same effect as non-smokers.

Perhaps 10% of the total population takes minor tranquillizers in any given year, but there is wide variation among different groups. Women, the old, and the chronically ill are the most likely to be given these prescriptions. Thus, elderly women are the highest consumers.



In Manitoba, 25% of women and 12% of men older than 65 years were found to be using two or more psychotropic drugs at the same time.

Women consume two-thirds to three-quarters of all psychotropic drugs, and take them for the longest period of time. This is not accounted for by their increased use of doctors. If a man and a woman go to a family doctor with the same symptoms, the woman is more likely to be given the tranquillizer.

Participation in the labor force is also a factor. In one study, 11% of women with full-time jobs were taking the drugs, 19% of part-time workers, and 25% of those who worked only in the home.

The authors say existing information on benzodiazepines has limitations. Sales or surveys usually determine the extent of use. But, sales statistics don't include hospital and institutional consumption, and give no indication of how much of the drug was actually taken, or by whom.

Surveys also exclude hospital and institutional use, are subject to the recognized limitations of user recall, and rely on the user's being able to identify what he took.

Neither method includes the substantial illicit use of these drugs. Nor is there enough information about their use in nursing homes, mental retardation centres, and prisons, where they are "widely dispensed as a means of behavior control."

Clinical trials are frequently conducted on young, healthy males, while the commonest users are old, chronically-ill females.

The extent and implications of polydrug use are under-explored, as are the problems of withdrawal after normal use.

The authors call for computerized prescription records, such as Saskatchewan has had since 1977. With such a data bank, trends in prescribing, relationships between drug-taking and diagnosis, prescription refilling practices, and correlations between prescribing and doctor and/or patient characteristics, could be delineated.

Controlled studies are needed to investigate the claim that products with a shorter half-life are safer, and more efficacious, in the elderly.

In exploring the etiology of tranquillizer use, the authors say universal medicare in Canada, coupled with the public's lack of knowledge about social support services, the costs, and the stigma sometimes attached to them, results in more family, work, and personal problems being taken to physicians.

At the same time, much of medical education is based on "the disease model of illness, which in its essence sees the individual body as a machine to be repaired by chemical or mechanical intervention."

Benzodiazepines can bring short-term positive results to both doctor and patient when social problems are expressed as emotional pain or distress. The patient may sleep better after a few days on the drug, may have immediate relief from incapacitating anxiety, or may be relieved of difficult obligations at home or work because he is "sick."

"The doctor feels he has done something for his patient, and thus relieves his own frustration; simultaneously, by the giving of a pill the doctor reinforces his own and the patient's belief that the locus of illness resides in the individual."

Peer review and self-audit are suggested as possible ways of getting physicians to examine their prescribing habits. Some studies show that doctors in group practice prescribe fewer drugs of all kinds. Perhaps because they have more time for discussion with patients, they can use other professionals such as social workers and nurse practitioners, and there is more discussion and continuing education among colleagues.

A doctor's prescribing habits may also be influenced by drug salesmen and medical journal advertisements.

"Psychotropic advertisements tend to promote extension of the definition of medical problems to encompass the stresses of daily living, and to further the belief that certain illnesses must be 'coped with' through continuous drug use. Several studies have demonstrated negative stereotyping of women and the elderly in drug advertisements, showing them as misfits who require drugs to endure, not change their situations."

The economic cost of continued tranquillizer use goes beyond the price of the drug to the patient or an insuring agency. The patient may also continue visiting doctors, "the most expensive component of the system," longer than necessary. And there are the physical and psychosocial costs incurred through toxic reactions, adverse reactions, and overdoses.

Also, insurance coverage for prescriptions may increase use. In the US, anti-anxiety agents jumped from 4% to 10% of the top 40 drugs after Medicaid was introduced. In Britain, prescription sales have dropped as prescription charges were increased.

And questions remain: With their sedating properties and ability to impair cognitive and learning functions, how often do benzodiazepines cause a masking of emotions, and what effect does this have on perception of reality?

Do they impair ability to deal with difficult situations, and lessen motivation for change?

"The quality of family life and interpersonal relationships potentially affected . . . may be far-reaching, given the proportion of our population consuming these drugs."

On a broader scale, "the possibilities of impaired decision-making, decreased learning skills, released aggression, and impaired ability to empathize have a significance extending beyond the lives of these individuals to the community at large.

"With the exception of alcohol, a larger proportion of the adult population probably uses benzodiazepines on any given day than use any illicit drugs."

**Published by Health and Welfare Canada.*

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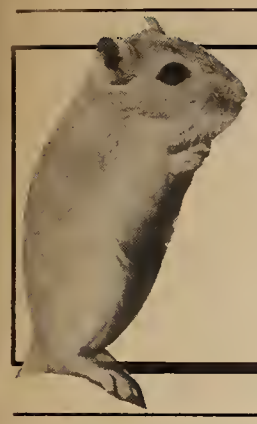

Gerbils on prison drug patrol

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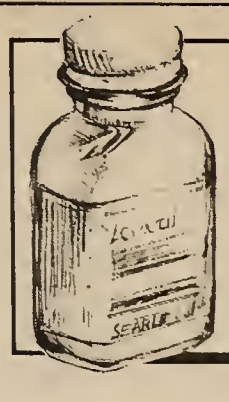

A drug, a multinational, and the Third World

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Vol. 11 No. 7 2nd Class Mail Reg No. 2776 TORONTO July 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Urine testing for cannabis will soon be widespread predicts DuPont

By Harvey McConnell

WASHINGTON — Urine testing for marijuana use will become widespread in North America over the next five years.

Its use will extend from members of the military, through air traffic controllers, pilots, and nuclear power plant employees, to students and production line workers.

This is the prediction of Robert DuPont, president of the American Council on Marijuana, and former director of the United States National Institute on Drug Abuse (NIDA), where he pushed for development of an inexpensive, reliable urine test for marijuana.

Within the past 18 months such test kits have become available and are being used in a variety of settings.

Dr DuPont told **The Journal**: "This allows an objective answer to a question which could not be answered before: Has a particular person used marijuana recently, or has he or she not?

"I hope people can really grasp what is going to happen because the technology is driving the politics and attitudes in this area. Society has evolved a high level of drug use, and we're going to have some painful times as we come off this decade-long, drug epidemic and this is one of the ways it is going to happen."

There are areas in society where marijuana use is incompatible with public safety, and other areas where it is incompatible with public confidence. Institutions in these areas "are now going to be forced by an interplay of public concerns into the use of urine tests," Dr DuPont continues.

How reliable are current tests? p2

At the moment, the cutting edge is the US military, where widespread random testings are being carried out, and some law enforcement agencies.

Dr DuPont believes, because of the public safety issue, pressure will soon spread for testing to be done on air-traffic controllers, airline pilots, inter-state bus drivers and personnel, and people who run the railroads.

The same goes for areas of public confidence, Dr DuPont continues, citing the nuclear power industry as a good example. "They

(See — Industry — page 2)

Lobby group aims for stricter enforcement

Canadians on move against drunk drivers

By Mark Kearney

TORONTO — A grassroots movement has started in Canada to get drunk drivers off the roads, and ensure laws against them are strictly enforced.

The Citizens Against Impaired Driving (CAID) is launching a media and public awareness campaign this summer to voice their outrage about the thousands of Canadians killed each year on roads by drunk drivers. The CAID also plans to lobby legislators to pressure judges to step up enforcement of penalties for impaired driving.

Karen Mitchell, founder and president of the Ontario branch of the CAID here, says the laws against drunk driving are generally adequate, but the enforcement is poor. Too often, a person convicted of the offence is given "a slap on the wrist."

This can be true even when someone has been killed, Mrs Mitchell says. And family and friends who grieve over the loss of a loved one are also victims of this injustice.

"It (drunk driving) is just not treated as a serious offence," Mrs Mitchell told **The Journal**. "It's kind of a joke."

Mrs Mitchell has first-hand experience with this injustice. Three years ago her nine-year-old daughter Jennifer, who was enjoying some summer bicycling, was killed when a drunk driver hit her from behind. The man was sentenced to two years less a day in prison.

"That's it. That's shocking," she says. "In a few months he'll be out, and back on the road again."

But Mrs Mitchell is confident that pressure from the CAID will prevent this from happening in the future. Although the CAID's Ontario branch was only started in late May, there are already 70 members and others in the province have made inquiries, she says.

The CAID got its start in Manitoba last November and the idea is spreading throughout Canada, Mrs Mitchell adds. Another branch has started in Edmonton, Alberta, and there are plans for others in British Columbia and New Brunswick.

She is now preparing information kits for new members, drawing up an organizational constitution, and gathering facts on legislation and drunk-driving statistics. The Manitoba group has already contacted that province's attorney-general, and Mrs Mitchell expects to do the same in Ontario in the near future.

She has also contacted the Toronto police to share information, and discuss how they may help each other. Police will be able to direct any victims of drunk drivers to the CAID, she says.

"We have their support and certainly their sympathy," Mrs Mitchell adds. Her branch is also hoping to establish a victims' crisis centre that will help with such things as funeral arrangements, or monitoring court cases of the drivers involved.

Mrs Mitchell stresses the CAID is not a prohibition or temperance group and right now there are no plans to lobby against such things as beer and liquor advertisements.

However, there are plans to lobby at the federal level when the group becomes larger, and to have citizens from every province involved in the project.

The CAID has also established contacts with the American-based Mothers Against Drunk Drivers (MADD) group (**The Journal**, Feb), and is sharing information and literature with them, she says.

Membership in the CAID is $5 single, and $10 for a family. Information can be obtained by contacting Mrs Mitchell at 72 Ringley Ave, Toronto, ON M8Y 1T5.

RCMP watching drug patterns as US puts squeeze on Florida

OTTAWA — Royal Canadian Mounted Police (RCMP) are on the alert for drug criminals seeking out new bases of operation here following the United States clampdown on the drug trade in Florida.

However, although some changes in drug movements have been seen here, Superintendent Rod Stamler, officer in charge, Drug Enforcement Branch, says the patterns have to be consistent before authorities can say the changes are a result of what's going on in the US.

"Right now, the information we have is that the subjects of the attack, the traffickers (in Florida), are looking at other possibilities.

"They are not going to face great risks in Miami (the chief port of entry to North America for cocaine), when they can change their patterns and establish in other areas or use another system."

In June, The Journal reported that officials in New York and other northeastern US cities were worried that the tougher war against trafficking in South Florida would worsen their problems.

NY Congressman Leo Zeferetti said President Ronald Reagan's administration was addressing the problem with a "crisis-management approach by shifting, rather than increasing resources."

Supt Stamler says: "Whatever you do (in one place) shifts patterns greatly. It's like a balloon. You push it in one place and it bulges in another."

He says the short-term effect on traffickers is that they are temporarily shaken. The long-term effect is that they take new tacks.

For the moment, he says, authorities here fear more that there could be an increase in drugs, particularly cocaine, moving through Canada to the hungry and much larger US market, than any dramatic increase in drug use.

"What makes a difference is if they get Canada established as a port of entry to North America. Once they start operating through a country, it's very difficult."

In the meantime, Supt Stamler says cocaine is now second only to marijuana in popularity as far as illicit drugs are concerned.

INSIDE

NEWS

Briefly...

Giant athletes

MINNEAPOLIS — A new synthetic hormone, crescormin, could soon be producing a generation of giant athletes. Dr William Taylor, director of sports medicine for the United States Sports Academy in Mobile, AL, says some bodybuilders are already using the drug, which costs $10,000 for a year's supply. The drug is not available to the general public, but some parents have expressed interest in it hoping it can turn their children into huge football players, says Dr Taylor. The production of the drug is expected to be up, and the prices down, by next year.

Stricter laws

COPENHAGEN — Random spot checks for impaired drivers should be stepped up, says the World Health Organization (WHO) in a report on the influence of alcohol and drugs on driving. Noting an appreciable increase in traffic accidents when blood alcohol levels of 0.05% are found, the report recommends stricter punishment of drunk drivers, and better educational programs, especially for children who have not yet reached driving age.

Drug diary

OTTAWA — The Sandy Hill Health Centre here has received a $32,000 federal grant to produce a *Drug Passport Booklet* for the elderly. The booklet is for recording all medicines taken by the owner, may be filled in either by a health professional, or the user, and is expected to be a valuable future reference for users of prescribed drugs. Health and Welfare estimates that people older than 65 years consume 25% of all prescription drugs in Canada.

GPs unhelpful

LONDON — A recent survey here shows that 54% of former alcoholics questioned after a year's sobriety felt their doctors had been irrelevant in their overcoming the disease. Dr Roger Hunt, a North Devon general practitioner, said the survey carried out in conjunction with a local group of Alcoholics Anonymous "astounded and appalled" him. The survey also showed that 10% of the 50 patients in the study felt their GP had done them actual harm by delaying recovery, and only 4% thought the GP had been a major influence in recovery.

Alcohol Insurance

AUSTIN — Texans now have the option to receive coverage for the treatment of alcohol and other drug dependency in group health insurance policies. The special bill, which came into effect earlier this year, was passed by the Texas legislature to battle the $3 billion cost to Texans of alcoholism's role in lost productivity, health care, and motor vehicle accidents. The number of Texans afflicted with alcoholism and other drug dependency is estimated at more than 820,000, including 80,000 children between age seven and 12.

High-dose diazepam therapy may help schizophrenics

By Austin Rand

TORONTO — Diazepam, sold under many trade names, including Valium, may gain a new use as a medication against schizophrenia, suggests a Canadian study reported here at the annual meeting of the American Psychiatric Association.

Joannis Nestoros, assistant professor of psychiatry, McGill University, Montreal, and leader of the research group involved, presented results indicating that massive doses of diazepam — up to 400 mg daily — rapidly and effectively reduce schizophrenic symptoms, without producing sedation.

Doctors prescribing diazepam for control of anxiety in their otherwise normal patients typically suggest a daily dose of 10 mg to 40 mg.

Such low-to-moderate doses of diazepam have also been tried against schizophrenia, always without effect, Dr Nestoros said.

However, he said, there are theoretical reasons for believing diazepam *should* work against schizophrenia, which affects about 1% of the population at some time in their lives.

One hypothesis about the disease, which frequently produces dramatic symptoms such as hallucinations, catatonia, and delusions of grandeur or persecution, is that an insufficiency of the neuroinhibitor GABA, or gamma-aminobutyric acid, underlies the problem. Diazepam is known, Dr Nestoros said, to potentiate or strengthen GABA activity in the brain.

The Montreal researchers first ran a pilot study in which 10 schizophrenics who were resistant to commonly-used, anti-psychotic drugs were given up to 300 mg of diazepam daily.

Instead of being completely sedated by these massive amounts of tranquillizer, as the normal person would be, seven of the patients improved.

After a few weeks of treatment, with decreasing doses since the patients' sensitivity to the medication increased as they got better, four of the patients were released on an out-patient basis. The others remained hospitalized but had a "much-improved quality of life," Dr Nestoros said. All seven continued taking a moderate, daily, maintenance dose of diazepam.

Encouraged by these results, the Montreal researchers went on to a full, scientific trial, placebo-controlled and double-blind.

All the responders in the pilot study had been paranoid schizophrenics, so Dr Nestoros and coworkers decided to test diazepam specifically with this type of schizophrenia.

Nine patients were assigned to receive placebo while another nine got diazepam. The two groups were similar in all respects, and had been hospitalized for an average of six years.

High-dose diazepam — ranging from 70 mg to 400 mg daily, with a mean of 208 mg — turned out to be remarkably effective, said Dr Nestoros, both during the first week of the study, when diazepam was compared against placebo, and during a subsequent six-week period when it was compared against the most commonly-used anti-psychotic, haloperidol.

Only one of the placebo patients improved during the first week of treatment, while eight of the nine patients receiving diazepam showed a marked reduction of symptoms, in some cases within hours of the first, large dose of the drug.

To illustrate, Dr Nestoros showed a videotape of one patient. A patient interviewed just before treatment began could hear voices and see saints lined up by the wall. A few hours after the first diazepam dose, the voices were gone, though a faint hum was left, and the saints had disappeared.

"We were expecting to see an anti-psychotic effect," Dr Nestoros told **The Journal**, summing up his evaluation of the results, "but not such an impressive one. When you see the apparent normalization of people, within a few hours in some cases, it is remarkable. We have not seen anything like this before."

Each of the patients responding well to diazepam has been placed on a low to high maintenance dose (average of 42 mg daily), Dr Nestoros said.

To date, patients have been followed for up to a year, and some relapses have occurred, but these have been easily managed by returning temporarily to a higher dosage level.

Dr Nestoros grants there is, at least theoretically, some danger that the diazepam-maintained patients will become addicted, but said so far there have been no signs of physical or psychological dependence.

Three patients who abruptly stopped taking the drug while they were at a high dosage level (respectively 80 mg, 100 mg and 390 mg daily) had an immediate return of their schizophrenic symptoms, but did not have other withdrawal symptoms, such as convulsions.

Dr Nestoros, who is a PhD in neurochemistry as well as a psychiatrist, said that he can see no theoretical reason why high-dose diazepam should not be effective against various forms of schizophrenia, though paranoid schizophrenics, "who have a lot of unfocused anxiety," would be particularly good candidates

Urine tests for cannabis still need refining

TORONTO — How reliable is urine testing for marijuana use today?

If a person undergoes a test and the result shows positive does that reflect with 100% accuracy the person has smoked marijuana?

Bhushan Kapur, director of clinical laboratories at the Addiction Research Foundation (ARF), says the technology is advanced enough today to conclude that a positive test means the person has used the drug.

However, it is difficult to determine how recently the person has smoked marijuana, he says.

"With the studies we've done, our data suggest that if a person is a chronic user, then 15 to 17 days after stopping smoking a person may still show positive," Dr Kapur told **The Journal**.

What can't be determined yet with absolute accuracy, he says, is whether the person smoked marijuana yesterday, or two days ago, or a week ago. Dr Kapur says as more research is done over the next few years a test with that accuracy may be developed.

That may be important if Dr Robert DuPont's theory of more widespread use of testing becomes reality. (see page 1) There are a number of social issues such as individual rights that may be raised if people are dismissed or prevented from doing their jobs because of a positive test result, Dr Kapur adds.

He says it's also necessary to have back-up tests especially if such evidence will be used in court in the same way an alcohol breath test is used.

However, it could be difficult to establish a cut-off point for drug levels in the body similar to the 0.08% level used in Ontario to determine if a person is over the legal limit of alcohol intoxication. Dr Kapur says each person has a different tolerance level and it may be hard to say who is being affected by a drug.

He's not sure he can agree with Dr DuPont who says that if the drug is "still in the body, then it is still having an effect."

Other considerations that will have to be made as the urine testing becomes more widespread is how the drug entered a person's body. For example, if a person is in a room where marijuana is being smoked but doesn't smoke it, will a test show positive?

Industry will see pot-testing soon: DuPont

(from page 1)

will not be able to operate nuclear power plants without being able to reassure the public that the people who are in those plants are straight (**The Journal**, June)."

In three years or so, he says widespread testing will begin in the schools and in industry.

Within the next six months, Dr DuPont's organization plans to hold a conference on marijuana urine testing for employers "because most employees don't want to know, and they have resisted the idea of urine testing for any drug for the past decade."

As for the social consequences of widespread testing, "it is purely good as far as I'm concerned."

From the user's point of view, as well as the community's, drug use will become objective. A sanction, or consequence, for drug use is the incentive essential for people not to use drugs. People need a reason not to use drugs, he adds.

"What we are talking about is establishing some values in society which say drug use is a bad idea."

Dr DuPont considers it essential to remember that "urine is positive if the drug is still in the body, and if it is still in the body, then it is still having an effect. It seems to me so obvious.

"We are *not* talking about anybody who has smoked marijuana, had a drink, or even shot heroin in the past. We are talking about current, in-the-body presence of a psychoactive drug which is associated with job performance. Now how can anybody say this, in fact, is not in the rights of society, or an employer, or a parent, or a school official, to have a concern about?"

Dr DuPont believes the question of whether urine testing violates an individual's civil liberties "is a fake issue. I think a lot of people tend to react to drug abuse as though it were a political issue as opposed to a humanistic issue, as opposed to an issue of real pain, and of real consequences to families and communities."

As far as he knows, there have been no successful civil rights challenges against urine testing for drugs and alcohol, and he does not think there will be. "What I think will happen is that the so-called civil rights protection the drug users are expecting is going to simply evaporate."

One fallacy, he believes, is that drug use and abuse policies are a conservative versus liberal issue.

Dr DuPont says pressure on those in leadership positions will change. Until now, for example, any army-company commander, or high school principal, or company director who admitted he had widespread drug use among his charges would be accused of being an incompetent leader. Now, with widespread urine testing, the incentive will be for those in power to try to identify it, and to deal with it.

NEWS

Fathers get warm understanding

Women blame mothers for family alcohol woes

By Mark Kearney

TORONTO — Women who have one or both parents who are alcoholics almost always blame the mother for the family's problems, says a New York doctor.

And, in many cases, the daughters themselves become alcoholics.

"It seems that the mother, whether she herself is an alcoholic, or she is the spouse of an alcoholic, remains the main source of conflict for her daughter," says Matilda Rice, assistant clinical professor of psychiatry, University of New York, Stony Brook.

Dr Rice presented a study of 171 alcoholic women and 64 non-drinking women at a symposium at the American Psychiatric Association annual meeting here. She found that 59% of alcoholic women had alcoholic fathers, 23% had alcoholic mothers, and 11% had both parents alcoholic. The statistics were similar for the non-drinking women who had married alcoholic men.

"Because the mother plays the more-important role in child-rearing in our culture, the effect of an alcoholic mother can be more serious than that of an alcoholic father," Dr Rice says. "Since she is usually drinking at home, her physical presence cannot be avoided, and the children bear the brunt of her regression and unstable behavior."

This is in sharp contrast with daughters' attitudes to alcoholic fathers who play a different parental role in our culture, she says. In most cases, the daughters ally themselves with their alcoholic fathers, and often take care of them, pick them up and take them home from bars late at night, and bail them out of jail if necessary.

"The alliance with the father is not uncommon, and is a reflection of culturally-reinforced attitudes which are different toward the mother as compared with the father," Dr Rice says.

In interviews, women with alcoholic mothers said such things as: "I cannot forgive her for drinking;" "she never did anything for me, I felt like I was her mother, I had to clean after her when she was wetting the bed;" "I never had love;" "I never had a childhood."

In interviews with women with alcoholic fathers, the statements tended to reflect more warmth and understanding: "I liked my father better because he cared more;" he was "a great guy, compassionate." This last statement was made of a father who was in the last stages of alcoholism. Some other daughters whose fathers died from drinking blamed their mothers for killing them.

Dr Rice said these findings about alcoholic women and their relationships with their parents have to be viewed in the context of the overall drinking problem that has developed with women recently.

She says 10 years ago one of every six people with an alcoholic problem was a woman. Now it's one of three. Women account for 28% of Alcoholics Anonymous' total membership.

"Alcoholic women show more disturbed family backgrounds, higher incidence of depression symptoms, their drinking is mostly concealed, and they are overprotected by their families," says Dr Rice. "Once women establish heavy drinking patterns, they generally develop alcoholism more rapidly than men."

She says studies show alcoholic women often have a fragile sense of their adequacy as women. They drink to gain heightened feelings of womanliness. However, with heavy drinking comes neglect of appearance, disapproval of friends and family, and reduced ability to meet demands of home and work, Dr Rice says. This eventually makes her feel less of a woman, causing her to drink even more heavily.

Dr Rice says family disturbance is even greater when both parents drink. However, there is no evidence to suggest the future of a female child is influenced in any special way by this situation. The general trend of the daughter directing her hate toward the mother seems to remain, she adds.

Dr Rice added that alcoholic women with alcoholic mothers started to drink earlier in life (about age 13) than other women. All the women in her study said their lives would have been different if their mothers hadn't been alcoholic.

Rice: Mothers main source of conflict.

OMA seeks hospital smoke ban, pot education

TORONTO — The Ontario Medical Association (OMA) would like to see a complete ban on smoking by anyone, anywhere, in hospitals.

Its general council took the stand at its annual meeting here, but only after long debate.

While opponents of the resolution weren't advocates of smoking, they argued about feasibility. "You can't legislate behavior," said one. Another pointed out that many hospital patients were old, with habits that were hard to break. A third said a doctor's job is education, not coercion.

Dr John Hill of Barrie said there should be a concentrated program for quitting, and not a move "to make patients uncomfortable just because they happen to have an addiction."

He cited a patient who drinks, smokes, uses Valium (diazepam), and weighs 250 pounds.

"So you put him on a 1,000 calorie diet, with no sleeping pills, booze, or cigarettes. If you think you're going to accomplish anything, you're crazy. All you get is a nice, warm feeling that you're doing something."

Passage of the resolution doesn't mean hospitals in Ontario have to act on it. They'll be notified of it as a recommendation from the 14,500-member association.

The council also endorsed a recommendation from its public-health committee calling for more education of the public and the medical community about the harmful effects of cannabis.

Although the OMA policy is that "there be no change in legislation that will encourage the use of cannabis," at the same time the council called for adjustment of current laws "to reflect the realities of use so that the effects of exercising the law do not turn out to be more injurious to the individual than the harm that comes from occasional use of low levels of cannabis."

The OMA also supports funding for systematic, prospective studies into the medical effects of cannabis, "particularly in those suspected of being at greater risk, such as women of child-bearing age."

The public-health committee noted an increase in cannabis use in the last decade, mostly among the young, including women of child-bearing age.

"There has been demonstrated danger from moderate and heavy use in an acute as well as a chronic stage, though mild use appears to have understandably less effect. Dangers identified include the precipitation of psychoses and the impairment of performance of complex tasks in acute situations, respiratory changes (greater than with cigarettes), and changes in germ cells in chronic use."

Taking 'the fifth' on BAL

WASHINGTON — The United States Supreme Court has agreed to rule whether the refusal of a driver to take a blood alcohol test may be used as evidence in court on a drunk-driving charge.

The long-standing controversy, which arises from an appeal from the state of South Dakota, is whether the introduction of a refusal to take a blood test violates the driver's protection under the fifth amendment of the Constitution, which protects a person from incriminating himself.

Early wisdom hazardous to intellectual health

By Wayne Howell

I recently paid a visit on my old friend and erstwhile adviser, Professor Bottomsworthy. I found him in his cluttered university office, huffing and spluttering over a report on his desk.

"Look at this," he said, shoving the report in my direction. "It's the results of a mail survey of 1,106 graduate students enrolled in schools of nursing, medicine, social work, and counselling programs in the Boston area.

"Medical Foundation Incorporated, a research organization, determined the attitudes of these future, health-care workers regarding the treatment of people with alcohol-related problems. They found that one out of three students felt few people were able to overcome drinking problems even with treatment, and two-thirds foresaw eventual relapse for alcoholics who had achieved sobriety. In general, they did not feel there was any good treatment for alcoholism — other than AA (Alcoholics Anonymous) — and even though they professed belief in the disease concept of alcoholism, they doubted alcoholics' ability to recover, and were reluctant to treat them. The researchers were naturally discouraged by these findings, and they concluded that the problem was 'inadequate training'."

"That sounds reasonable to me," I said.

"Nonsense," said the professor, "according to my analysis the problem is not inadequate training, it is the very converse."

"I'm afraid I don't follow you."

"Look at those results. Obviously these students have become victims of some sort of premature burn-out phenomenon. They have become as jaded and cynical as old veterans of the alcohol-counselling trenches even before they have seen a shot drunk in anger. If anything, their training has been too good — and that's bad."

"Now I really don't follow you."

"Let me explain. The idealism and optimism of the young is a valuable commodity in society; our educational institutions should conspire to nurture it by inculcating positive attitudes toward our capacity to effect changes through increased knowledge, scientific and non-scientific. I'm not suggesting that this inculcating of positive attitudes should be taken to ludicrous extremes. For instance, I just heard on my radio that June is 'Seniors Month,' a month in which we are to 'learn to think of aging as a positive thing, the beginning of the end of a useful life.' What nonsense: there is nothing positive about getting old and dying — it is the worst thing that could happen to anybody, next to dying young.

"But I'm not talking about ludicrous extremes. I'm talking about inculcating positive attitudes to break down prejudices and encourage people to take a crack at the really tough problems in our society, one of which is alcoholism. It doesn't matter that the possibilities are more apparent than real.

"We all need myths of one sort or another to live by, even if it is the myth that there are no myths. And the curious thing is that if the myth is strongly held it can, up to a point, actually become a reality. For instance, we are all familiar with the charismatic nature of certain therapists. They believe that they can 'cure' their clients with their particular program and that belief is so strong it rubs off on the client and he does, in fact, become cured."

"So you're saying that as long as people believe they can help others they just may be capable of helping them."

"Exactly. And the problems with these students, as I see it, is that they just don't seem to have that belief, or if they had it, they had it drummed out of them by their teachers. They should be coming out of those health care programs with some fire in their bellies and some belief in the efficacy of their various disciplines. But they appear to have acquired the attitudes of cynical old cranks like me, even though they haven't paid their dues; they haven't seen enough of the world to have come by their cynicism honestly."

"But are they not just wise before their time?"

"Oh they are. They most definitely are. That is precisely the problem. Because what is the wisdom of the old and/or the experienced? It is: 'leave well enough alone,' 'it will never work,' and 'I told you so.' If the Wright brothers had become wise at an early age, we would still be strapping feathers on our arms and taking Icarus-like dives off docks and bridges, not cruising the skies in 747s."

"It sounds to me like you want our educational institutions to keep students — even graduate students — in a state of suspended naivety. I should think that would have even worse consequences in the long run; we'd be strapping on feathers and taking Icarus-like dives off cliffs."

"No I don't want that; knowledge is one of the most precious resources that we have, and without it our chances of alleviating medical and social ills are poor. But there is one resource even more precious than that; it is the only one that did not escape when Pandora injudiciously opened the box containing her marriage presents from the gods. I am speaking, of course, of hope. We should be giving students knowledge and hope, and then let them get "wise" on their own time, in their own way. With luck, some of them never will — .they'll buzz about like bumblebees, pollinating and cross-fertilizing for the rest of ther lives."

"I'm afraid you've completely lost me."

"It is a scientific fact that bumblebees cannot fly: the ratio of body-mass to wing-span precludes flight. Fortunately, there are no graduate schools for bumblebees. That may explain why so many of them manage to fly."

NEWS

Now, tranquillizers are under-used: Lehmann

MONTREAL — Minor tranquillizers such as Valium (diazepam) are being seriously under-used to treat stress and anxiety, says Heinz Lehmann, psychiatrist and director of psychopharmacology at the Allan Memorial Institute here.

"Physicians and patients have become so terribly scared of them that patients who should be treated are not," he told the Canadian Science Writers' Association meeting at McGill University. "I meet again and again people suffering from anxiety for whom doctors will not prescribe tranquillizers." He said too often the unrelieved state of tension leads to serious mental illness.

Dr Lehmann blamed the media and the movie *I'm Dancing as Fast As I Can* based on television-producer Barbara Gordon's struggle to overcome dependence on tranquillizers, for frightening physicians and patients into believing the drugs are addictive and hazardous, and he told science reporters they should try to set the record straight.

Dr Lehmann said doctors have swallowed the media line that they prescribe too many tranquillizers. He said it used to be that way six to 10 years ago. "But it's not that way anymore." He said prescriptions for Valium in the United States have dropped dramatically from 61.3 million in 1975, to 33.6 million in 1980, and that while Valium was once the most frequently-prescribed drug in the US, it had dropped to fourth place by 1980, "and is now in fifth or sixth place." He told the science writers they "haven't come up to date."

Frederic Grunberg, associate professor of psychiatry at the University of Montreal, agreed: "The media have taken a moralistic approach." He scolded reporters for preaching that "anxiety is part of life, as it has been since time immemorial, and people are no less able to cope today than in the past."

As a result, Dr Grunberg said, patients who need tranquillizers resist taking them, fearful they'll become addicted.

Dr Lehmann added that tranquillizers are not needed for minor stresses that everybody experiences once or twice a day such as being caught in a traffic jam. But they are beneficial for major stresses such as missing an important business meeting, losing a job, or failing an examination. Most people have major stresses every two to three months, he said. In those situations, the stress can far outlast the event, making the person unable to function as well as he or she should.

Dr Lehmann said prescriptions should be limited to two months. In cases where the drug is taken for longer periods, he said "it should not be withdrawn cold turkey."

Neither psychiatrist mentioned that, as recently as last December, two new studies by Ontario doctors, reported in the *Canadian Medical Association Journal*, found too many doctors are prescribing too many tranquillizers, and that physicians prescribe them about twice as often for women as for men. The studies were conducted by Drs Martin Bass and Jon Baskerville at the University of Western Ontario, and by Dr John Anderson at Queen's University, Kingston.

Nor did they mention a book published by Health and Welfare Canada by Ruth Cooperstock, scientist in social policy and epidemiology at Ontario's Addiction Research Foundation, and Jessica Hill, social worker, and Ontario regional director for the health promotion directorate, Health and Welfare, Canada (**The Journal**, June).

In the book, *Effects of Tranquillization: Benzodiazepine Use in Canada*, the authors caution anti-anxiety agents should not be taken continuously for more than two weeks, yet in the more than 100 studies of use they reviewed, they found widespread, long-term use.

Dr Sidney Wolfe, director of the Consumer Health Research Group in Washington, DC, says Valium "is very addicting. At first it was thought to be addicting only in high doses, but now it's known to be addictive in regular doses." (A typical adult dose is 10 mg to 20 mg a day.)

Gerbil patrol sniffs out drug trade at Canadian prison

TORONTO — People trying to smuggle drugs in or out of a federal prison have a new nemesis — the gerbil patrol.

The Correctional Service of Canada is spending $60,000 on an experiment, started in June, using gerbils to sniff illegal drugs being carried into or out of Warkworth Medium Security Institution in Campbellford, Ont.

"Drugs do pose a serious problem at all our institutions," says Dennis Finlay, the service's chief of media relations. In some cases, inmates who have caused problems have done so because they were under the influence of a drug.

Mr Finlay says the service is optimistic the gerbils will be successful in detecting the drugs, and, if so, the project will be extended to other institutions.

The gerbils, animals known for their keen sense of smell, have been trained by a Toronto firm. They will be hidden near the entrance to the prison, and will push a lever activating a red light if they detect drugs on prisoners and visitors as they arive or leave.

Mr Finlay says the gerbils are a good animal for this because they are relatively cheap to keep, can be trained, and have a good sense of smell. The burrowing rodents have been used by customs and excise officials in the past to detect drugs being smuggled into the country at airports, Mr Finlay adds.

Gerbils will be hidden near prison entrance.

The service is hesitant about giving out too many details about the project for fear it could harm the success of the experiment. Mr Finlay says the gerbils can detect street drugs, but he won't say which ones.

"If we told you which ones, then they (the smugglers) would bring in the ones that can't be detected."

Gerbils are also sensitive to adrenalin, and they will activate the red light if they detect a high flow, which may indicate a person is trying to conceal something, Mr Finlay adds.

The publicity the project has received so far may end up acting as a deterrent, he says, as smugglers now know which prison has the gerbils and may put off any attempts to bring drugs into the prison. While this is one of the service's goals, it may make it more difficult to determine the success of the experiment, Mr Finlay says.

The Warkworth experiment won't be the first time gerbils have been used in prisons. In an unsuccessful test at the Cowansville Medium Security Institution in Quebec last year, the team of gerbils died, possibly from drinking contaminated water.

Lawyer challenges Food and Drugs Act

BC's 'magic' mushroom sales may be legal

COURTENAY, BC — Whether one pound of mushrooms is the same as one lb of psilocybin is being weighed in the courts here.

Lawyer Edward Holecamp maintains that sale of "magic" mushrooms is not against the law. Schedule H of the Food and Drugs Act says nothing about mushrooms, but outlaws psilocybin, the active ingredient in the *Psilocybe mexicana*, and some other species.

Mr Holecamp's client, also of Courtenay, was charged in 1980 with trafficking in psilocybin after he unwittingly sold one lb of "magic" mushrooms to two undercover RCMP (Royal Canadian Mounted Police) officers for $3,000.

A trial judge subsequently ruled that mushrooms themselves are not a restricted substance, in a finding that was upheld by the British Columbia Court of Appeal. The case is now before the Supreme Court.

Although psilocybin has been prohibited since 1974, prosecutors have had difficulty applying the law to mushrooms because not all mushrooms in the same growing area always contain the drug. Soil and climate factors influence production of psilocybin in the five species of potentially-hallucinogenic mushrooms which grow wild in BC.

The majority of successful prosecutions have been for the provincial offence of trespassing, a charge laid against mushroom pickers who venture on to private farm land in their search for magic mushrooms.

Earlier this year, an Alberta trial judge ruled that a man arrested for having two kg of peyote buds could not be convicted of possessing mescaline because buds aren't specifically mentioned in the Food and Drugs Act; only mescaline, a product of the buds, is identified. An appeal in the peyote bud case is being delayed until the Supreme Court of Canada hands down a decision on the mushroom case from Courtenay.

RESEARCH UPDATE/ Austin Rand

Pot cigarettes contaminated

United States-government-issue marijuana cigarettes contain substantial numbers of bacteria which could cause serious lung infection when the cigarettes are used by people whose immune defences are down, say Dr Thomas Ungerleider and colleagues from UCLA (University of California, Los Angeles) School of Medicine. Controlled therapeutic use of marijuana is now permitted in 32 US states, the authors note, and "legal" marijuana represents only a small proportion of the marijuana used by cancer patients. Lung infections rarely develop among healthy individuals, the authors say, because of the enormous capacity of the healthy lung to inactivate bacteria. Patients receiving chemotherapy, radiation, or, in the case of leukemia, immunosuppressive drugs, are a different story, however, since all those agents impair the antimicrobial defences of the lung. Also, marijuana smoke itself is now believed to impair the phagocytic or bacteria-destroying capacities of the scavenging cells found in the lungs, and marijuana-caused lung infection from the fungus *aspergillus* has been reported. What to do? The authors have tested sterilization of marijuana cigarettes and report that it does not affect delta-9-THC content. They suggest that sterilization might be a useful precaution when the cigarettes are destined for cancer patients.

Cancer Treatment Reports, March 1982, v.66:589-590.

Wine, please

Heavier-drinking women tend to choose wine, not beer or liquor, as their beverage, indicates a study of 238 social drinkers drawn from a Chicago suburb. Overall, men reported drinking twice as much as women — an average of one drink per person per day compared with one drink per person every two days among the women — but when consumption of specific beverages was analyzed, it turned out that the greater male consumption occurred with beer and particularly with liquor. While males who preferred beer, liquor, or wine all consumed roughly equal total amounts of alcohol each month, female drinkers who preferred wine consumed significantly more total alcohol than did female drinkers who preferred beer or liquor. When it came to wine, female and male drinkers were equal in monthly consumption. The study also supported the popular idea that relatively few drinking women really like beer: 10% named it as their favorite beverage, while 38% chose wine, and 52% chose liquor. By contrast, among the drinking men in the sample, 51% opted for beer as the preferred beverage, 21% picked wine, and 28% chose liquor. The study, which had a response rate of 87%, also found that, of the total sample of 311, 18% of the males and 28% of the females were abstainers.

International J of the Addictions, 1982, 17: 315-328.

Relief for hayfever?

Is caffeine a medication against hayfever? Possibly, indicates a one-subject study that a medical student performed on himself, with sufficiently interesting results that his observations were recently published in *The Lancet*. Philip Shapiro, of Albany Medical College, New York, noted that after taking two tablets of the caffeine-containing pain-killer Excedrin, for relief of a headache, his allergic rhinitis — the inflamed, stuffy nose that accompanies hayfever and many other allergic reactions — diminished. Intrigued, and aware of the fact that xanthines like caffeine decrease release of histamine (a protein degradation product that is associated with symptoms of allergy), Mr Shapiro decided to evaluate the effects of caffeine vs placebo in a blind experiment. He obtained eight 140-mg caffeine doses from NoDoz tablets, packed the caffeine in gelatin capsules, and made up eight, identical-looking tablets which contained sucrose. He took the tablets, in random order, on 16 consecutive mornings, and recorded his sneezes and overall discomfort. Increased alertness from the caffeine did not occur, he says, so he was unaware of what he was taking. When he broke the code, it turned out that caffeine had significantly reduced both the number of sneezes and overall discomfort, and was associated with a trend toward decreased pruritus or itching. In a subsequent comment on these observations, a group of Italian doctors notes that a cup of strong, black, Mocha coffee was an accepted therapy for allergic asthma 100 years ago.

The Lancet, April 3, 1982:793 and May 15, 1982:1133.

Alcoholism stigma deters open discussion: Begin

TORONTO — There is too little research being done in Canada on mental health problems, says Health Minister Monique Begin.

And while more money is needed to battle the problems, including the increasing rate of alcoholism in Canada, it falls under the jurisdiction of the provincial governments and not of the federal government in Ottawa, she says.

"I think it is fair to say that the low volume of research in mental health . . . is more reasonably ascribed to the lack of qualified researchers and proposals than to any internal, governmentally-determined policy or procedure. There is an inadequate supply of trained researchers."

While the government can support research to some extent, "in the last analysis" the commitment and leadership for such study has to come from within each professional group, she said at the American Psychiatry Association annual meeting here.

As for the problem of alcoholism, Ms Begin told **The Journal** that it still remains "the quiet problem."

"It's the old problem. There's still a stigma attached to alcoholism. People don't want to talk about it."

Ms Begin praised organizations such as the Addiction Research Foundation of Ontario for its work in bringing the problem out into the open. However, that doesn't seem to be enough because the problem is worsening, she says.

Ms Begin said this trend is common in many countries. She recently attended a World Health Organization meeting in Geneva where alcoholism was one of the many problems discussed.

"We (in Canada) are often amazed at the very basic problems some countries have to face. It was interesting to see that all of us are having to cope with alcoholism."

Begin: It's the old problem.

Daily cannabis use on increase: Ontario study

By Mark Kearney

TORONTO — The proportion of daily users of marijuana has increased to the point where it's about the same as that for alcohol, says a province-wide survey by the Addiction Research Foundation.

The report states 10.6% of those surveyed admitted using marijuana nearly every day (the same percentage as those who use alcohol) compared with 6.3% in 1977. The proportion is also nearly the same as that for daily users of sleeping pills and stimulants, which were 10.9% and 12.5% respectively.

"Clearly, in the past 10 years marijuana has gained a popularity which is very similar to that of the more traditional drugs such as alcohol and the commonly medically prescribed drugs," say ARF scientists Reginald Smart and Edward Aldaf, who prepared the report.

"To be a daily cannabis user is no more unusual than to be a user of several other drugs."

The scientists also noted that while daily drinking hasn't increased since 1977, "significantly more respondents reported having five or more drinks in one sitting over the past year."

The survey shows 57.3% responded positively to that question compared to 51.5% in 1977. However, the researchers caution against seeing this as a trend, noting that the increases may be short-lived.

Trends in Alcohol and Drug Use Among Ontario Adults: Report of a Household Survey, 1982 is one in an on-going series designed to examine drug use in this province. The previous survey was in 1977. In total, 1,040 adults more than 18 years of age were surveyed during a week in February of this year.

The survey also found that 6.8% of the total sample used sleeping pills in the last 12 months, 3.3% used stimulants, 8.6% used tranquillizers, 8.8% used marijuana, and 78.6% reported ever using alcohol. The most significant change from 1977 was in tranquillizer use which had been 13.2%.

The changes in drug use are not numerous but they are of considerable interest, the two scientists say: "It may well be that concern about the over-prescribing of tranquillizers which has often been reported is having some effect."

Other major findings in the report:

- Tranquillizer and sleeping pill use were significantly more common among the oldest adults.
- Use of stimulants was significantly higher among young adults (18 to 29 years) than other age groups.
- Use of marijuana significantly decreased for professional and executive occupational groups (10.7% in 1977 to 5.1% in 1982) although there was no change in the population as a whole.

GILBERT

'. . . If cigarettes were made dearer, stronger, and less available, maybe fewer of them would be smoked by young people . . .'

Stopping young people from smoking

By Richard Gilbert

In April and May, I wrote about two ways of reducing overall cigarette consumption by Canadians that could have an especially strong effect on cigarette use by young people. This month I want to describe a third means of reducing cigarette consumption — one that would affect only smoking by teenagers and even younger children.

The means described in April was raising the price of cigarettes. I noted that part of the relentless increase in per capita cigarette consumption by Canadians since 1949 can be attributed to falling real prices. I concluded that cigarette consumption could be halved if the real price were doubled in the course of a year in three, equally-spaced increments. Smoking by young people would decrease by even more than 50% because, on average, they have less disposable income than adults.

In May, I noted that most of the increase in cigarette smoking by Canadians since 1949 can be attributed to the progressive 'weakening' of cigarettes by manufacturers. This has been achieved chiefly by physical manipulation of the tobacco leaf. The leaf is puffed and fluffed so that less of it is required to hold firm a tube of cigarette paper. As a result, today's cigarettes weigh much less and yield much less tar to a standard smoking machine than did the cigarettes of the 1950s. Smokers usually smoke more cigarettes when they are mild than when they are strong. Girls seem especially likely to smoke more when cigarettes are weaker. I noted that the progressive weakening of cigarettes may have been an important factor in the encouragement of smoking by young women.

Two laws

This month I want to propose that young peoples' smoking be reduced by enforcing existing laws respecting sales of cigarettes to minors. There are two laws concerning juveniles and tobacco in effect in Ontario. A long-standing federal law, the Tobacco Restraint Act, forbids the possession or use of tobacco products in a public place in Canada by anyone under the age of 16 years. The maximum penalty on first conviction is a reprimand; on second conviction, a fine of $1; on third and subsequent convictions, a fine of $4. Police are obliged to confiscate the smoking materials. Police in Toronto have rarely laid charges under this act, although they sometimes use it as authority to warn kids not to smoke.

An Ontario law, the Minors' Protection Act, makes it an offence to supply tobacco in any form to a person under 18 years. An exception is made when the minor is on an errand for a parent or a guardian, and is bearing a written request. The maximum penalty for giving tobacco to a minor is $50. I spoke to officials in many Ontario government ministries and in the Metropolitan Toronto police department. None could remember a charge being laid under this act, or even a complaint. It is certainly not enforced. The opinion was expressed that, as now written, the legislation restricting the sale of tobacco to juveniles is unenforceable both because of the difficulty in getting useful evidence and because public sentiment does not favor laying charges.

But public sentiment may be changing. A recent survey for Health and Welfare Canada indicated that just about half of all Canadians would favor further restrictions on the sale of cigarettes. Also, although the proportion of young people who smoke is declining, it is not declining as rapidly as the proportion of young people among smokers. Thus, there is a higher proportion of young people among smokers. Their smoking seems correspondingly more evident. The latest data for Ontario, gathered in 1979, suggest that some 19% of males aged 15 to 19 smoke regularly, compared with 37% of males aged 20 years and older, and some 22% of females aged 15 to 19 smoke regularly, compared with 29% of females aged 20 years and older.

Store sales

Studies in Britain and Australia, where similar laws prohibiting the sale of cigarettes are in place, have shown that most children who smoke regularly buy their cigarettes in stores. An unpublished study for Health and Welfare Canada suggests that about 80% of cigarettes smoked by juveniles may be purchased by the young smokers themselves. There is no direct evidence that actively restricting the sale of cigarettes to young people would reduce their use of them. There is evidence from work on the sale and use of alcohol that may be relevant. A recent review of this work by staff of the Addiction Research Foundation concluded that an increase in the frequency of off-premise outlets is accompanied by an increase in consumption. The relationship between frequency of on-premise outlets and consumption was not found to be so clear.

Thus it seems that one route to reduced teenage smoking might be better-enforced restrictions on the sale of cigarettes to them. Clearly the existing legislation and its enforcement are inadequate. Also, it is questionable whether the police should be enforcing what is essentially a law about public health.

Two government agencies are already supervising the sale of tobacco. One is the Ontario Ministry of Revenue, which ensures that the tobacco tax is collected. More direct supervision is exercised by the Metropolitan Licensing Commission, which requires each vendor of tobacco products in Toronto to have a licence. Currently, the licence is $28 a year per establishment, typically an insignificant proportion of the turnover for this kind of item. Neither agency appears to take much of an interest in the question of illegal purchases of cigarettes by juveniles.

Licensing by-law

Perhaps the way to reduce teenage smoking by restricting access to cigarettes, if this is possible, would be to make the effective legislation a licensing by-law rather than a provincial statute. Vendors would be required not to sell cigarettes to young people as a condition of their licence. Licensing Commission inspectors, suitably reinforced, would provide the enforcement, the extra funds being found from an increase in the licence fee — and thus, indirectly, a modest increase in the price of cigarettes. Compliance might be ensured by the vendors' fear of losing their licences.

All of this would be of no use if it produced no change in the amount of smoking by young people. Research is needed first to determine just how much teenage smoking can be reduced by making it more difficult for them to acquire cigarettes in this way. Different municipalities in Ontario could he used for a study of the effects of better enforcement of the existing law. Some leads might be provided by what happens in stores where there is an attempt to obey the law and those where there is not. One chain of news-stands in Toronto (Garfield's — you see them in the subway stations) has a strong corporate policy of not selling cigarettes to minors, and requires the posting of clearly visible signs to this effect, but its impact is unknown.

My hunch is that if cigarettes were made dearer, stronger, and less available, many fewer of them would he smoked by young people. Indeed, I would venture that this package of changes would have far more impact than all the persuasion and education in the world. Persuasion and education would still be necessary, however, to caution the incorrigible, and to sustain knowledge in the community of the dangers of this particularly vicious drug.

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Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

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Citizen's personal crusade behind DWI clampdown

The Journal (May) front-page story — US moves on drinking drivers — is deeply appreciated by all concerned citizens who want stiff laws that will encourage drinkers to refuse to drive after drinking.

And, it is true that a letter signed by 341 members of (the United States) Congress got President Ronald Reagan's attention. But it is regrettable that the full story was not told.

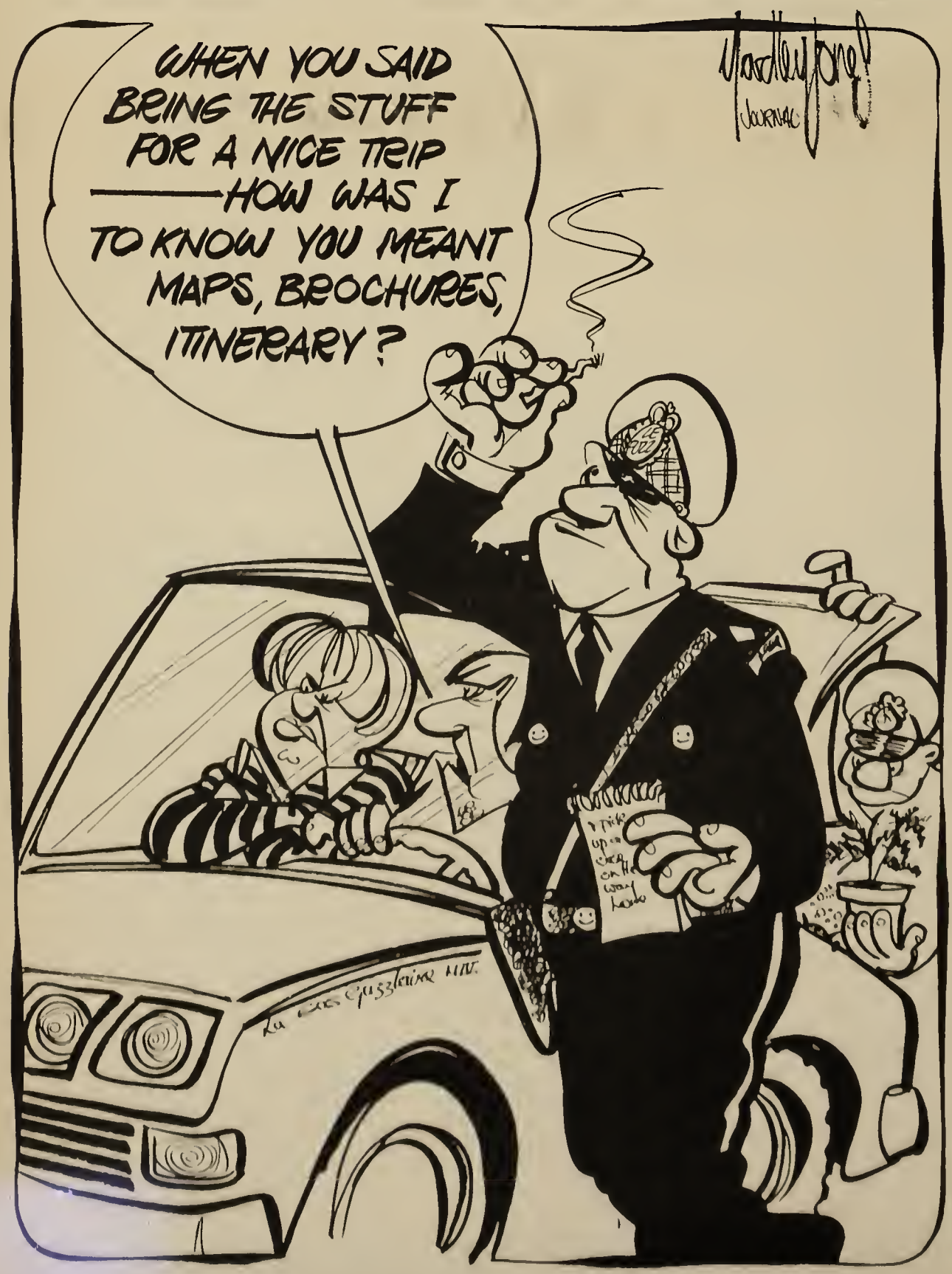
A letter sent to the President on Sept 17, 1981 and signed by state leaders at our annual meeting (of the American Council on Alcohol Problems) in Minneapolis, MN, was the FIRST request for a Presidential Commission. The letter (dated Oct 6, 1981) from members of Congress, except for deleting one short paragraph, is identical.

Sandy Golden, (a journalist) from Gaithersburg, MD, spoke at our Minneapolis meeting, and requested this letter to the President. He later worked with Congressmen (Michael) Barnes (Dem-MD), and (James) Hanson (Rep-UT), on this issue. Mr Golden has been on this personal crusade for two years.

I do not know why the media has chosen to ignore him, but all of us who know the total truth believe his story needs to be presented to the public.

Rev Richard E. Taylor, Jr
President,
American Council
on Alcohol Problems,
Washington, DC

PS: Kansas Governor (John) Carlin, on May 12, 1982, signed the first stiffer drinking driving law changes since 3.2 beer became legal in 1938. The new law prohibits plea bargaining, sets mandatory jail terms with no parole, and higher fines, and revokes the licence for refusal to take a BAC (blood-alcohol concentration) test; refusal to take such a test shall be admissable as evidence on a DWI (driving-while-intoxicated) charge in court. In March, (Governor Carlin) appointed the Governor's Committee on Drinking and Driving. I am one of seven members.



Alaskan concerned

As a health professional, I have an abiding concern in all aspects of health care and treatment-prevention. The misuse of drugs, especially with its resultant deleterious effects, is particularly interesting, as I've run across a broad spectrum of abuse in this area of Alaska.

I have heard **The Journal** is an excellent publication in this field. I am writing now to request a sample current issue, and details on subscription/membership.

Ken Souza, MPH, RD
Maniilaq Association
Kotzebue, Alaska

RN vetoes drug therapy in alcohol withdrawal

I am reading, with delight, the lead article in The Journal (May): Care is key in alcohol withdrawal — drug therapy is unnecessary.

As a registered nurse, I have long advocated most of the main points in the article, and have been severely criticized for my stand in insisting on giving less drug therapy. I have detoxified alcoholics at home — using food instead of tranquillizers, giving milk and juice every two to three hours with added protein in the form of soy products.

I condemn further the usual hospital practice of taking vital signs when a patient's stomach is empty. This prolongs further the time in which drugs are unnecessarily given. Some clients leave treatment centres still very toxic with a return to alcohol (use). No big surprise.

Jane M. Kiiley, RN
Seattle, Washington

Plato recalled

I was most impressed by the well-researched, full-page article, Plato's thoughts recalled in 1980's research on alcohol and pregancy (**The Journal**, March).

Ronald Forbes
Executive Director
ALFAWAP
London, England

TJ 'excellent resource'

We have developed an Alcohol Awareness program for our campus. The Committee has come across **The Journal**, and finds it most helpful.

The Journal is thorough, creative, and of course informative. The special supplements are particularly good. We look forward to begin receiving **The Journal** regularly. Thank you for an excellent resource.

John Butler
Fort Worth, Texas

Happy 10th anniversary

May I congratulate you and all other members of the editorial staff for the 10th anniversary of **The Journal** (June).

I think **The Journal** performs a very valuable service. I am very happy to note that in the recent years there is considerable coverage of the problems related to developing countries.

Dr Narendra N. Wig
All India Institute of Medical Sciences
New Delhi, India

The Journal welcomes Letters to the Editor. Letters, bearing the full name and address of sender may be sent to: The Journal, 33 Russell Street, Toronto, Canada M5S 2S1.

COCAINE TODAY

In Canada, cocaine is now second only to marijuana in the illicit-drug popularity stakes.

In the United Sates, nearly 10 million people beyond 11 years of age reported having used cocaine in 1978-79, more than double the number of users the previous year, says a report from the US National Institute on Drug Abuse. It shows cocaine-related deaths in the US quadrupled to 272 in 1980 from 61 in 1976, and cocaine-related hospital treatment increased six-fold from 1975 to 1981.

Nevertheless, many in the general public, and even in the substance abuse field itself, still mistakenly regard cocaine as a safe, and even glamorous, recreational drug.

To "elucidate and educate," the American Council on Marijuana and Other Psychoactive Drugs recently held, in Santa Monica, California, a conference entitled Cocaine Today. Speakers included doctors, researchers, and clinician-experts on cocaine, as well as representatives of the parents' movement, and of the media.

The consensus among the experts is that the outlook is very grim if cocaine's popularity continues to grow.

This month, in this special section, The Journal's **Contributing Editor Harvey McConnell covers the experts' views, and a move by top Hollywood writers, producers, and directors to try 'not to present an attractive aspect to drug abuse.'**

Next month: Scientists, parents, and young people: have the messages been mixed?

Speakers:

Dr Robert **DuPont**, president of the American Council on Marijuana, and former director of the US National Institute on Drug Abuse;
Dr F. R. Jeri, researcher and consultant psychiatrist, Ministry of the Interior, government of Peru;
Dr Gabriel Nahas, College of Physicians and Surgeons, Columbia University, and a long-time marijuana and cocaine researcher;
Dr Robert Petersen, former assistant director of research at US National Institute on Drug Abuse, and author of the yearly US Marijuana and Health Reports;
and three researchers and clinicians who have dealt directly with thousands of cocaine abusers, including many celebrities:
Dr Sidney Cohen, clinical professor of psychiatry, Neuropsychiatric Institute, University of California, Los Angeles;
Dr Ronald Siegel, psychopharmacologist, Neuropsychiatric Institute, University of California, Los Angeles; and
Dr David E. Smith, founder and medical director of the Haight-Ashbury Free Medical Clinic, San Francisco.

Robert DuPont

F. R. Jeri

Gabriel Nahas

COCAINE TODAY...COCAINE

I submit that if this country (the United States) had unlimited supplies of inexpensive, high-grade cocaine, the number of cocaine-dependent people might be counted in the tens of millions.

That's the view of Dr Sidney Cohen, and he says only the extremely high price of cocaine and its generally low quality in the street markets are holding back the future.

Dr Robert DuPont says: "I consider cocaine the great reinforcer, the most intense, dependence-producing drug that we have, the great hook that is going to and already has hooked many people into a very deep and very dependence-producing pattern."

The statements set the tone at the Cocaine Today conference where the consensus among scientists was that "misinformation, disinformation, a glamorous image, and media hype" have left the majority of people ignorant about cocaine's awesome power.

They don't know about what the experts here call "cocaine whores" who will do anything for a fix, the "coke bugs" addicts see in hallucinations, or the paranoia, often violent, which can overwhelm intravenous users, and freebase smokers especially. And they don't know about the second addiction to alcohol or heroin that can come when users try to deal with the acute depression that follows prolonged use of cocaine.

Nor do most know of the "cocaine hunger" which can haunt addicts as they try to give up the drug, and the "cocaine dreams" that can recur again and again over the rest of a recovering addict's life. As with the recovering alcoholic, one slip can restart the nightmare for an abuser.

Even users themselves, claim the experts, are unaware cocaine can be lethal. After the recent death of television and film comic, John Belushi, from an overdose of cocaine and heroin, scores of addicts came to the doctors. "I didn't know cocaine could kill you," they said.

Dr David E. Smith says it has long been known in scientific circles that people can die from a cocaine overdose. "You have to work at it a little harder to kill yourself, but it is certainly possible. There has been a recent, dramatic rise in overdoses in New York, a majority by injecting, a minority by freebasing, and a few by snorting. It is possible to get enough into the system to kill yourself."

Origins

Cocaine originates in South America where coca paste is extracted from the leaves of the coca bush, and the paste refined into the popular white powder — cocaine hydrochloride. There is widespread use of both forms in Peru and Bolivia, the producer nations, and in Equador, Colombia, Brazil, and Argentina.

In Peru, says Dr F. R. Jeri, coca paste, which is smoked in a cigarette with tobacco, contains between 40% and 90% cocaine. In two experiments with smokers, scientists found the paste produces euphoria, dysphoria, and "hallucinosis" within a five-minute period.

Those who smoke paste are poor, the well-off snort the powder. Dr Jeri says it's not unusual for police in Peru to confiscate 1,000 pounds or more of paste in a raid, and scores of judges, lawyers, doctors, legislators, police, and civil servants have been convicted of accepting bribes from international drug rings.

The effects of cocaine are similar to those of amphetamines: cocaine gives a more pronounced "high," while amphetamine effects last longer. Dr Robert Petersen notes that cocaine abusers given intravenous doses of both drugs have been hard put to tell the difference.

Dr Petersen adds: "The 'speed freaks' of a few years ago have gotten a bad press, whereas cocaine continues in this glow which began 100 years ago, and is a symbol of status in the bizarre way we have of bestowing such things in America."

Official surveys of cocaine use in the US, like surveys with every other drug, are misleading, he says. "We tend to minimize based on the small number who use weak stuff infrequently. And each generation almost says 'ha, see how safe it is. There is no real problem. It's just big brother in Washington or elsewhere who wants to curb our pleasure.' "

Dr DuPont points to another factor bedevilling the public's view: the terms "infrequent user" and "frequent user."

"The media have a tendency, like a moth drawn to a flame, to go after and dramatize a report, and give the public the impression that the use of a drug intermittently and recreationally is okay.

"The fallacy of this point of view, I think, is that drug use is along a continuum, it is connected, and it isn't as though we had two separate phenomena (infrequent as opposed to frequent use). We see this very much in the alcohol field trying to separate the alcoholic and the social drinker, which makes it difficult to educate people. Nobody starts out to become dependent, they start out as an occasional user.

"The occasional users runs a very substantial, unpredictable, uncontrolled risk of ending up in that other end of the continuum."

Craving

Most street cocaine is heavily adulterated. People snort it, inject it into a vein, smoke it by adding an alkali and solvent to the powder (freebasing).

Dr Ronald Siegel says freebasers believe, incorrectly, that they remove all the adulterant in what they think is a reversal of the chemical chain. They don't.

Negative effects of cocaine? Dr Cohen says that putting aside the hypertension, racing heart, danger of an overdose death, disintegration of the nasal septum, or lung damage, the thing which impresses him most about users is the overwhelming craving for the drug.

"There is no other drug or human activity that compels the user to persist repetitively in its acquisition like cocaine does."

Monkeys rewarded with cocaine when they press a bar will ignore food, water, or a sexually-receptive mate. "As many as 12,800 unrewarded bar presses have been counted before the researcher got exhausted, but not the monkey who still hoped for another fix," he says.

Addicts go on binges and snort, inject, or smoke until supplies are exhausted. They are overtaken by dysphoria and extreme depression, the "coke blues," and may contemplate suicide until the next hit, when the cycle starts again.

Dr Cohen: "I have seen enough compulsive users to be deeply impressed by their untenable situation. They may have lost everything by the time they seek help — their friends, their job, their self-respect.

"They borrow from whom they know, or don't know. Many become untalented thieves and hustlers, or 'cocaine whores.' They will do anything for one more fix. Their close relatives are in a predicament; they have been lied to, robbed, they want to help, but feel helpless. Promises to stop are rarely kept."

Dr Cohen believes the question of whether cocaine is physically addictive is irrelevant. "The psychological ups and downs are so intense for these people that physical withdrawal symptoms are unnecessary to perpetuate the habit."

It is his impression that the ordinary pleasures of living become less pleasurable after innumerable cocaine experiences. "Loss of ability to feel pleasure is theoretical, but it is consistent with the observed inability to enjoy what was once enjoyable. If this is so, then the only remaining rewards are the chemical stimulants."

Some cocaine addicts can kick the habit, "but many have gone down the golden tube to a miserable existence that started out in exactly the opposite direction."

The freebasing fad started around 1974 and Dr Siegel blames the paraphernalia industry. "(It) promoted the smoking of freebase as 'the ultimate high,' as an ecstatic, orgasmic experience that was far and above that which would be achieved by snorting. Most of the people we work with now were introduced to freebase through the industry."

Robert Petersen

Sidney Cohen

Ronald Siegel

David E. Smith

TODAY... COCAINE TODAY...

A six-year study he and his University of California, Los Angeles (UCLA), colleagues began in 1975 of 85 men and 15 women cocaine users shows that over the years more and more of them have started to smoke freebase.

Only about 5% of the cocaine placed in the freebase water pipe bowl, volatized into smoke, and inhaled, actually gets into the lungs. "Yet that causes significant toxic reactions, so we can see the potency of this material to begin with."

Compulsion

Freebase addicts will go to any measure to extract the last nanogram of the drug and "try to circumvent all the problems" by rebasing the water, the scrapings from the pipe, and even their own sputum from the lungs.

Dr Siegel: "The onset of the effects are rapid: three minutes into the brain from snorting, 14 seconds from intravenous use, and six seconds from freebasing."

Freebase episodes can last as long as 120 straight hours, and addicts can spend $2,000 to $12,000 a week for cocaine. "Their use is compulsive, and you don't see social or recreational smoking, you don't see titrated adjustment. It is compulsive use which has escalated beyond individual control," Dr Siegel adds.

As for the depression, paranoia, and hallucinations, Dr Siegel had one patient present him with 10 vials "filled with a gunky, white substance which the patient told me were 'coke bugs.' It turned out, under the microscope, to be dry skin tissue which he had scratched off."

Several of Dr Siegel's patients have taken pot shots at him. One was found, when overpowered by police, to have "two guns loaded with dum-dum bullets, a small grenade, fireworks, and an army sling shot. He was successfully detoxified by being confined in jail."

Many cocaine addicts use alcohol or heroin to try and head off the depression and paranoia. Dr Smith: "A lot of users snort cocaine and use alcohol to counteract the depressant effects, or so they can stay up all night in an upper-downer cycle. A lot of patients are entering AA (Alcoholics Anonymous) when really alcohol is the secondary problem, and this is confusing a lot of AA groups."

Other cocaine addicts try to counter the depression by smoking heroin. "And while these people have said they would never use a needle, they discover the truth that all addicts must eventually discover, and that is that the best route is intravenously."

The most dangerous combination is "speedballing," the simultaneous use of cocaine and heroin.

Dr Smith again: "Patients have told me they want the intense euphoria of a cocaine injection, but don't want the rapid fall off they get with cocaine alone, so they mix in heroin to give them a consistent narcotic euphoria.

"They go to extremes to titrate their dose: I had one patient who had friends inject him simultaneously in one arm with cocaine and the other arm with heroin."

Overdose deaths from cocaine are caused by "kindling," often called reverse tolerance, caused by repeated use of a drug.

Dr DuPont says this has been well known for decades in neurology: "That is, repeated administration of a substance which can produce convulsions can, at a lower than threshold level, if repeated long enough, produce convulsions."

Sex and cocaine

A cocaine overdose "requires appropriate management of the seizure with intravenous diazepam and life-support system," Dr Smith says. Some patients have survived the initial toxic dose but succumbed to a rapid, potentially fatal rise in body temperature to 107°F and higher.

Sexual dysfunction is also a serious problem for many cocaine users. Dr Smith has many women report they experience their first orgasm while snorting cocaine, and both men and women report that cocaine, at first, enhances their sexual experiences.

Over time, however, the reverse happens: women report they have decreased desire, and men report erecticle and ejaculatory problems.

Dr Smith: "Most find that when they stop using the drug they don't return to the level of sexual functioning which predated their involvement with cocaine. And there are some people who started their sexual experience with the use of a psychoactive drug and they have never been normal."

Treating the cocaine addict is very difficult.

"I can report that our inpatient detoxification program is highly unsuccessful," Dr Siegel comments.

Ideally, Dr Cohen observes, there should be an antagonist drug for the cocaine addict but there is not. Antidepressants or lithium can be helpful initially "but the problem is, how do you get them into the patient?"

Dr Smith finds tricyclic antidepressants are only valuable "if the individual had an underlying endogenous depression which predated — and was not a consequence of — the cocaine abuse. I don't think medication should be used for the primary disease."

Antidepressants may be used in initial withdrawal because, with abstinence, cocaine psychosis can clear up within a maximum of 14 days.

As Dr DuPont observes, withdrawal from drugs, "difficult though it is," is not the problem. "Almost anything will work in getting over acute withdrawal.

"The problem with any drug of dependence is long term, and the problem of relapse. A person who takes that step (to give up) has to have some tremendous transformation to go on, and many of us in the drug abuse treatment field have failed to grasp how (necessary) that is and how difficult that is."

Problems for the recovering addict are enormous.

Loss of control

Dr Smith: "Every cocaine abuser I have ever met wants to return to controlled use and is waiting for someone to tell him it is possible. They see others using cocaine recreationally without any problems and they want to return to controlled use, but their life is a continued loss of control."

Dr Smith and his colleagues at Haight-Ashbury have drawn up a one to 10 scale for the recovering addict. "A one is a cocaine dream, and my experience is that they will probably have cocaine dreams for the rest of their life. They might decrease in intensity, and frequency, but the dreams will be there.

"A three is cocaine hunger and this is something they have to live with seven days a week. One patient gets cocaine hunger when he completes a grant application, another when he enters the anesthesia suite at a hospital, another when he hears a particular song.

"Most of the relapses occur within the first six months when cocaine hunger is most intense and they have not developed alternatives for handling it."

A 10 on Dr Smith's scale is a full-scale return to cocaine use. Dr Smith has one patient who had not used cocaine for a long period of time, saw friends using the drug, and tried it. "And he told me 'it was like somebody lit my brain afire. I can't believe the compulsion.' His withdrawal had to start all over again."

There is agreement that the recovering cocaine addict has to develop alternative ways of living in order to cope. Group therapy, Narcotics Anonymous, working with the person's family can help. And so, says Dr Smith, can running.

"I always tell people that Ron Siegel down at UCLA has developed something he calls 'slow, long-distance running.' And it works." Dr Siegel has patients who have been drug free for some time who are now runners.

As for the future, Dr Nahas believes "we need a national consensus backed by all the important forces in the nation, including the media, saying the use of these drugs is not acceptable in society."

And the aura of glamor must be removed. Dr Smith is appalled by criticism of the Los Angeles coroner for revealing that celebrities and well-known personalities have died from drug abuse.

"In my opinion, that is part of the problem. We are having addiction throughout our society, but when respectable people die from alcohol and drug addiction it is something you hush up."

...A new role for Hollywood

Panelists at a session on the media and public attitudes included: **Charles Champlin**, film critic for the *Los Angeles Times;* **Alan Courtnay**, television producer and chairman of the newly-formed producers, directors, and writers caucus on alcohol and drug abuse; and **Maurice Goodman**, vice-president of standards for the National Broadcasting Corporation (NBC).

Charles Champlin

Alan Courtnay

Maurice Goodman

A caucus on alcohol and drug abuse has been formed among the 125-or-so writers, directors, and producers in Hollywood who are responsible for 90% to 95% of prime-time television programs in the United States.

Alan Courtnay, chairman of the caucus, said it has only been in existence a couple of months "and I can't tell you our course of action as yet.

"However, we are determined to make whatever contribution we can toward urging our members — and we are careful to avoid any censorship, rules, or regulations — not to present an attractive aspect of drug use."

This attitude is reflected directly in a forthcoming television film to be shown on the National Broadcasting Corporation (NBC) network about a cocaine abuser. It is the story of a 45-year-old man whose business is doing so-so; he starts to use cocaine, business improves, and then the negative effects occur.

Although alcohol is legal, it too will be considered, Mr Courtnay says. "We are urging our membership not to gratuitiously show the use of alcohol. Let people walk into a room and pick up a cup of coffee, or a book, or reach for an object instead of immediately pouring themselves a drink.

"We realize that in the younger minds this creates the impression that achieving the status of adulthood is to immediately walk into a room and pour yourself a drink."

The caucus is going to suggest "there is a dereliction of creative responsibility if the best we can do is come up with situations that are funny because somebody is drunk, or because a group of people are 'stoned.' We are aware of the opportunity to present the negative aspects of drug use whenever we deal with it, and we are going to be vigilant in our efforts not to make alcohol or another drug attractive."

Maurice Goodman says he can only speak for the NBC, but he is sure the other networks feel the same way, "in that we are not going to show it as socially acceptable any more. Real drug abuse is an enormous problem facing our society."

Mr Goodman said the NBC cocaine film caused concern because in the middle of the original script it was indicated there may be something nice about cocaine.

"We worried because there would be those people who would say 'Eddy Gaines (name of the character) is different from me. I can handle it, and once I am up there driving a Mercedes with a phone in the front, and a pretty girl in the back, I'll be able to put a handle on it.'

"We had a long talk with the producer and writer, explaining why we appreciated their doing a movie showing the down side of cocaine, but, at the same time, it could be seen as glamorizing it.

"I think people tend to look at movies or television and, whether we like it or not, we are passively endorsing (drug use) if we show it on the network screen. It is best we don't glamorize it."

In the final version of the film, when the character, Eddy, is on a cocaine 'high,' the negative aspects are shown as well.

Mr Goodman says his network did not want drug-oriented humor, and there would be no tacit endorsement of it.

Charles Champlin, with the benefit of hindsight, wonders what effect the Hays Office code, which ended in 1968, had on the growth of the drug culture. (The code forbade any mention in movies of narcotics, good or bad.)

The one exception during that period was *The Man With The Golden Arm*, about heroin addiction, which starred Frank Sinatra, and which was released without a code of approval.

"But *Panic In Needle Park*, which I think is one of the very best films about the present-day horrors of street addiction, I would have thought would have done almost no business despite the presence of Al Pacino and a very good cast, just because it was a downer."

The difficulty in movies and television "is that the more harrowing you get about the real consequences of abuse, the less likely you are to engage an audience. It is rare that the art is so transcendent that people will go to see films that leave them depressed. That's too bad, but I think that is the way it is."

Mr Champlin says films both reflect society and widely promulgate ideas. The movies did not get ahead of society in depicting marijuana, and to a lesser extent, cocaine use, "but I think there is no doubt they were using it very carelessly indeed, and they were very irresponsible in the area of marijuana use."

On a personal level, Mr Champlin considers it "a national disgrace and a national tragedy that no one is taking the leadership to suggest what might be done about the drug problem except drug enforcement. Including looking across the ocean to England, where I lived for three years, where I think, despite the drug bureaucracy and the tax on the English, (maintenance of addicts) is a far more viable alternative than anything that has been attempted in this country."

As the tinsel curtain is raised on drug abuse by entertainers, Hollywood is asking: Have films and television encouraged drug use? Can they help to curb it? Richard Pryor has built his love-hate for cocaine into his night-club act; ex-addicts John and Mackenzie Phillips are now anti-drug crusaders; John Belushi is dead of a cocaine/heroin overdose.

Richard Pryor

John Belushi

John (below) and Mackenzie Phillips

'Individualistic' athletes smoke least.

Most athletes don't smoke — contrary to advert claims

GENEVA — Promotion by tobacco manufacturers suggesting that smoking and a sporting life go well together has been contradicted by two studies in France and Switzerland.

The studies, conducted in conjunction with the United Nations World Health Organization's (WHO) global program on smoking and health, say the majority of athletes, in fact, do not smoke.

In the French study, carried out by Professor J. C. Labadie of the University of Bordeaux, 60% of the 400 athletes surveyed were found to be non-smokers, and the other 40% light smokers.

The study shows that, generally, the more individualistic the sport, the less likely it is the athlete smokes. For example, up to half of football and rugby players covered in the survey are smokers while all the cyclists questioned are not.

Professor Labadie says 75% of athletes participating in sports at an international level are non-smokers.

Professor Theodore Abelin, of the University of Bern, says non-smokers covered 2.6km in a 12-minute run while the best distance for smokers — those consuming an average of 10 cigarettes daily — was shorter, just 2.3km.

A third study concerning the prevalence of respiratory illness in a sample of about 3,000 youths aged 12 to 19 years, carried out by Professor Arja Eskola of the Finnish Cancer Registery in Helsinki, found smokers twice as likely to catch cold, and four times as susceptible to tonsillitis as non-smokers.

The WHO says that "such facts as these are leading to a budding movement to disassociate smoking from sports. In the United Kingdom, for example, 10 top physicians have called for an end to the sponsorship of sporting events by the tobacco companies. Among them are the presidents of eight medical colleges, including Sir Douglas Black, president of the Royal College of Physicians."

Early this year, the Edinburgh-based Scottish Health Education Group launched a £250,000 anti-smoking campaign centering on the Scottish World Cup football team's public declaration of itself as "The Squad Don't Smoke" (The Journal, April). **In a resolution, the WHO's Executive Board has responded by calling on other teams "to emulate the Scottish initiative." Four other teams have done so thus far — those of New Zealand, Ireland, Czechoslovakia, and Kuwait.**

Global use of tobacco on increase in females

GENEVA — Teenage girls in North America and Western Europe smoke at least as much or more than teenage boys, a United Nations World Health Organization (WHO) preliminary survey has concluded.

And the rise in female smoking, combined with the ever-increasing use of oral contraceptives, creates considerable health risks later in life.

The WHO's International Clearinghouse on Smoking and Health finds that in 14 countries, including Canada and the United States, females aged 16 to 18 years smoke as much as, or more than, males in the same age group. With few exceptions, the survey shows smoking is on the rise for male and female teenagers — and that the older they are, the more they smoke.

However, in Canada and the US, the smoking rate for male teenagers is finally beginning to subside.

The number of teenagers surveyed in 22 countries ranged from 500 in Ethiopia to 100,000 in Canada. Other countries where girls have caught up with, or outsmoked boys are Holland, France, West Germany, Belgium, Denmark, Norway, Sweden, Greece, Italy, Switzerland, New Zealand, and Uruguay.

The WHO warns that, "the rise in female smoking, in combination with the use of oral contraceptives which has risen more than ever before, increases the risk later in life of circulatory disorders, such as cerebral thrombosis and hemorrhage, as well as coronary heart disease."

Mid-teenage boys have continued to out-smoke girls in Britain, Australia, India, Finland, Bulgaria, Ethiopia, Nigeria, and Papua New Guinea. In Sweden, a vigorous national campaign has cut smoking rates for both sexes continuously and substantially since the early 1970s. (**The Journal**, May.)

A specialist spokesman for the WHO has urged health authorities in more countries — particularly those in developing regions where smoking has emerged as a principal threat to public health standards — to collect reliable data on which to base their national anti-smoking campaigns.

Human costs 'incalculable'

WHO assembly wants clamps on alcohol

By Thomas Land

GENEVA — Alcohol-related problems have emerged as among the most serious public health concerns throughout the world, placing intolerable strain on the home, the health services, and industry, says a study prepared for the United Nations World Health Assembly. (The assembly determines policies of the World Health Organization.)

The study adds that a dramatic, current increase in alcohol production and consumption worldwide presents governments with a dilemma.

While alcoholism and related problems take a heavy toll on health, the production and sales of alcoholic beverages create jobs, profits, and tax revenues. The study — *Alcohol Consumption and Alcohol-Related Problems: Development of National Policies and Programmes*, the WHO, Geneva — appeals to governments "to restrict the availability of alcohol in the interest of the health and welfare of their populations."

Global production of beer has increased by 124% during the past two decades, and wine by 20%; the production of spirits has grown by some 60% between 1960 and 1972. Overall, production has jumped by some 500% in Asia, 400% in Africa, and 200% in Latin America, "reaching (even) the most distant villages."

Crippling problems——

The consequent increase of crippling, alcohol-related problems is therefore blamed on supply creating demand, rather than the other way round.

The study exposes the hidden effects of alcoholism on the family and home support systems, as well as on general medical services. The range of family problems includes poverty, marital discord, and spouse and child abuse.

"Job instability and financial insecurity within the family may be exacerbated by drinking," it says. In "one large industrialized country . . . more than 5% of the labor force suffers from alcoholism, lowering industrial productivity by 25%."

The study points to alcoholism among many executives, medical doctors, and other professionals as a result of "the stress of shouldering new and heavy burdens in rapidly-changing environments." It also notes an increased prevalence of heavy drinking among housewives.

In virtually all countries for which statistics are available, cirrhosis of the liver — often used as an index of the extent of general alcohol abuse — now ranks among the five leading causes of death among males aged between 25 and 64 years.

Excessive drinking can also lead to psychotic disorders, and to an increased risk of cancer of the larynx, pharynx, mouth, and throat.

Another measure of the size of the problem is that "between 30% and 50% of (all) fatal traffic accidents in the industrialized countries involve drinkers with a high level of alcohol or other drugs in the blood."

Conflicting interests——

The study acknowledges that "economically, alcohol is an important commodity." Almost everywhere, alcohol is promoted energetically although its effects rank among the primary concerns of public health administrators in most countries. It describes "the conflicting interests and values" inherent in the duality of the problem as "a new signal for alarm" pointing toward "incalculable human costs." (See **The Journal**, April)

It admits that "a complete elimination of the alcohol problem is nowhere feasible," and adds that "a more realistic goal would be the reduction of its extent, gravity, and duration." It recommends regulation of alcohol production, control of imports, and reduction of sales through limiting sales outlets and banning advertising.

Correction

The article, British alcohol experts lambast government (**The Journal**, May), referring to an editorial in the *British Journal of Addictions*, indicated the editorial was signed, and listed the positions of several signatories. In fact, the editorial was unsigned and the positions listed were those of people who had agreed only to comment to the press. The Dean of the Institute of Psychiatry should not have been included in the list. **The Journal** regrets the error.

UK alcohol agencies suffer from rivalry, overlap: study

LONDON — Britain's voluntary agencies in the field of alcohol misuse suffer from "serious deficiencies," says a joint study from the department of health and social security (DHSS), and the National Council for Voluntary Organizations.

The study team looked at ways the DHSS could most effectively help voluntary bodies and make recommendations about funding. But the conclusions did not bring smiles to alcohol agency workers. The team found that the four national bodies concerned with alcoholism — The National Council on Alcoholism, The Medical Council on Alcoholism, The Federation of Alcoholic Rehabilitation Establishments, and the Alcohol Education Centre — suffered from "rivalries and overlapping."

The report recommends setting up a single national body concerned with the development of local services and training to remedy these shortcomings.

Kenneth Clarke, minister of health, commenting on the report, said: "I must emphasize that the government has not reached any conclusions on the recommendations, but we do believe that it opens up issues which need to be resolved. Before decisions are reached, we are seeking the views of all those involved."

After reviewing the activities of the four bodies, the report says the problems and difficulties give government a poor return on the £300,000 it grants them annually. "We believe that the present division of roles between the four leaves them in an impossible situation, and that even if were they to amend their internal organizations and improve their relations with one another, continued conflict and misunderstanding would be inevitable."

NEWS

Ulcer drug, alcohol mix may heighten intoxication

By Austin Rand

TORONTO — One of the most popular North American prescription drugs — the ulcer medication cimetidine hydrochloride or Tagamet — shortens the time it takes to get to a peak concentration of alcohol after having a drink, and heightens that peak, indicates a study published in the *Journal of the American Medical Association* (May 28, 1982).

Starting from the fact the ulcer drug has chemical characteristics that could affect the metabolizing of alcohol, and noting that "drug-induced changes in ethanol elimination may have potential social and legal implications," Drs John Feely and Alastair Wood of Vanderbilt University School of Medicine decided to see what the effects of typical therapeutic use of cimetidine might be.

Drs Feely and Wood gave six healthy, male social drinkers a week of cimetidine (four 300 mg pills daily) followed by an experimental dose of alcohol, and a week of placebo, also followed by alcohol.

On days six and seven of each course of drugs, the volunteers abstained from alcohol. On the morning of day eight of each drug course, the volunteers took a drink of alcohol-laced orange juice. Doses were calibrated for body weight, with the average volunteer getting about two ounces of pure alcohol.

BALs recorded

After a 20-minute period for sipping the drink, blood alcohol levels and self-assessed intoxication were recorded for the next seven-and-a-half hours.

On the "cimetidine" day, the blood-alcohol concentration peak arrived in 58 minutes, on average, while it took 79 minutes for blood alcohol to peak on the placebo day.

Also, after cimetidine, the peak concentration was 7.5% to 12.5% higher, with a mean rise of 10%. The mean peak blood alcohol was .146% after placebo and .163% after cimetidine.

As well, during the peak concentration phase, which started about an hour after downing the drink and lasted for about 30 minutes, subjective intoxication as measured by visual analogue scales was significantly higher after cimetidine. Indicating how drunk they were by drawing a line on a scale marked "completely sober" at one end and "very drunk" at the other, subjects judged they were 58% of the way toward being intoxicated after the placebo week, and 79% of the way after the cimetidine week.

Thus, while blood alcohol during the peak phase was 10% higher after cimetidine, subjective intoxication was 36% higher. Both results were statistically significant.

Finally, when blood alcohol level over the total length of the testing period was calculated, the average alcohol concentration was higher after the cimetidine week than after the placebo week.

Dr Wood told **The Journal** that though the data are interesting, interpretation should be cautious and conservative.

"The lesson from these data is not that an innocent person taking a simple drink, which would not have normally made them intoxicated, will now suddenly find themselves over the legal limit for drunkenness because they are taking a prescription drug for ulcers.

"The implication would be, rather, that one ought to be aware that this drug combination does not reduce risk of being drunk, and it might increase the risk, though not substantially," Dr Wood said.

He added that while blood alcohol was elevated after cimetidine, and while subjective assessments of intoxication correlated well with blood alcohol changes ($P < .01$), more testing would have to be done before it could be said that cimetidine definitely makes people feel and act distinctly more drunk on the same amount of alcohol.

Detailed studies

He said relatively large doses of alcohol were used in this study, and smaller doses might not produce significant differences in self-assessed intoxication.

The fundamental effect — the raising of peak blood alcohol concentrations by an average of 10% — might be produced by a variety of factors, alone or in combination, he said.

Dr Wood told **The Journal**, only detailed studies will make it clear exactly how cimetidine is affecting alcohol metabolism.

Given the widespread use of both cimetidine and alcohol, Drs Feely and Wood both believe further studies, both pharmacological and clinical, are necessary.

Pink lungs cure may be harmful, dear Ann

TORONTO — Smokers looking for ways to kick the habit with the help of some advice in a recent Ann Landers column may be doing themselves more harm than good.

The column, which is syndicated throughout North America, recently printed a letter from a 30-year-old smoker who suggested swallowing a pinch of tobacco with a glass of water to reduce the craving for a cigarette. The writer, who signed the letter Praying for Pink Lungs Soon, said the method relieved withdrawal pangs enough to allow him to give up cigarettes "in a fairly-comfortable manner."

Tobacco researcher Lynn Kozlowski, of the Addiction Research Foundation of Ontario, says he wouldn't recommend the technique.

Landers: wants progress report.

"Pharmacologically, it doesn't make sense," he says, although it could have had a placebo effect on the smoker. Dr Kozlowski adds that a person could become "very sick" if too much tobacco was swallowed.

The type of tobacco used would also have to be considered, he told The Journal. Swallowing cigarette tobacco would be worse than swallowing chewing tobacco, for example, because it's not as easily broken down in the body.

Children could also pick up the habit from their parents, Dr Kozlowski warns, and might become sick, or die, if too much tobacco was swallowed.

Meanwhile, Ms Landers, in her reply to 'Pink Lungs' says: "Nothing would please me more than to hear from thousands (of readers) saying they tried this technique and kicked the habit . . . Please write again in 60 days. I'd like a progress report."

This publication is indexed in

BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Susan Reid, the coordinator of the group, at (416) 595-6150.

The Glug

Number: 503.
Subject Heading: Youth and alcohol; trigger film; alcohol and the family.
Details: 15 mins; 16 mm; color.
Synopsis: This drama centres on a group of young teens, the "River Rats," who meet each Friday night to "glug" beer in a deserted boathouse. Tony seems to depend on his drinking while the other "Rats" can stop at will. His sister, Julie, who formerly had a problem with alcohol, notices Tony's drinking and tries to stop him. Tony starts lying to his parents, failing at school, and is unable to deliver his newspapers on time. When one of the "River Rats" is unable to get beer for their regular party, the group decides to go roller skating. Tony declines the invitation, steals liquor from his father, and drinks it alone at the boathouse. When he attempts to walk across a beam while drunk, he falls into the river and nearly drowns. His sister and a "River Rat" rescue him from the river and Julie tells him it's time to get help.
General Evaluation: Good (4.2). This contemporary, interesting, and well-produced film was judged to possess emotional impact and likely to produce attitudes opposed to teenage alcohol abuse. Although several members said the film did not provide a great deal of factual information (eg regarding etiology and treatment of alcohol problems), the group suggested that the film would be a good discussion starter, with a length appropriate for most educational settings.
Recommended Use: The film is likely to benefit its intended audience of teenagers (aged 12 to 18 years). It would also be beneficial to adult audiences. The presence of a resource person would be useful in facilitating discussion.

Smoking: How To Quit

Number: 506.
Subject Heading: Smoking; lifestyle.
Details: 16 mins; 16 mm; color.
Synopsis: A young married couple, both failures at giving up smoking, try to curb their habit through a process of gradual reduction. The wife joins a self-help group and assists her husband using the techniques employed at the weekly meetings. Such techniques include: marking down each cigarette smoked on a chart and rating its "pleasure" on a five-point scale; postponing the first cigarette of the day; creating obstacles to the smoking regimen; etc. Finally, the film suggests setting a "Zero-Day" and sticking to the date, rewarding yourself with a special purchase or treat.
General Evaluation: Good (3.9). This contemporary and informative film was judged to be a good teaching aid with a length appropriate for most educational settings. The group liked what the film said about methods for quitting smoking, and said it would be helpful with decision-making regarding smoking.
Recommended Use: The film would likely benefit its intended audience of adult smokers, teenagers aged 15 to 18 years, and to health professionals working with people trying to quit smoking.

Second National Driving Test — One For The Road

Number: 500.
Subject Heading: Impaired driving.
Details: 30 mins; 16 mm/3/4" video-cassette; color.
Synopsis: This tape, designed to involve the viewer, depicts more than 250 volunteer subjects participating in party games devised to be sensitive to the effects of alcohol, and in direct relation to skills necessary for driving. The participants (and in some instances, the viewer) perform 20 tests designed to measure their knowledge, skills, and ability to process information, both while sober and while under the influence of alcohol.
General Evaluation: Good (4.2). This contemporary, entertaining, and informative film was judged to be a good teaching aid, with a length which is appropriate for most educational settings. Although the group said the film was likely to produce attitudes opposed to impaired driving, many suggested that the subjects should not have been depicted consuming such great quantities of alcohol.
Recommended Use: Likely to benefit its intended audience of anyone aged 15 and older, including alcohol users.

DEPARTMENT

New Books by RON HALL

The Rehabilitation Of Clergy Alcoholics: Ardent Spirits Subdued

. . . by Joseph H. Fichter

Based on interviews with 63 recovered alcoholics, 43 staff personnel in 24 rehabilitation centres, and 28 church officials, the author discusses alcoholic clergy who have recovered from their addiction and investigates the rehabilitation process by which they were restored to the active ministry. From the data gathered in these interviews with both alcoholics and non-alcoholics, the most meaningful items were used to formulate a survey questionnaire for recovered alcoholic clergy. Of the 1,279 mailed questionnaires, 677 (52.9%) were returned. The style and content of this monograph are not geared to those researchers who are devoted mainly to statistically-precise, and empirically-tested hypotheses. The general framework in which the findings have been conceptualized involves four central concerns: ecclesial, vocational, moral, and spiritual. Maintaining that alcohol addiction is a complex phenomenon that requires interdisciplinary treatment, the author offers a view of the social, psychological, moral, and theological aspects of recovery.

(Human Sciences Press, 72 Fifth Avenue, New York, NY 10011, 1982. 203p. $19.95. ISBN 0-89885-009-6)

Man, Drugs And Society — Current Perspectives

. . . edited by L.R.H. Drew, Pierre Stolz, and W.A. Barclay

This volume represents the proceedings of the Pan-Pacific Conference on Drugs and Alcohol, held in Canberra, Australia, from Feb 26 to March 5, 1980. The contents include papers dealing with perspectives on drug and alcohol use in the Pan-Pacific region, social policy issues, cross-cultural perspectives on drug and alcohol use in Australia, as well as drug use and family life, and religion in relation to drug and alcohol use. Preventive education and professional education issues are addressed, as are topics in the clinical and social sciences. Treatment options and the development of integrated services, problems concerning alcohol and drugs in industry, and impaired driving are also focus areas. Preference has been given to papers not of Australian origin to ensure a good representation of contributions from the wider geographic and cultural context. Preference was also given to papers, the substance of which, was not known to have been published in comparable form elsewhere, and to papers which were brief.

(Australian Foundation on Alcoholism and Drug Dependence, PO Box 477, Canberra City, 2601, ACT, Australia, 1981. 474p. $25. AUS. ISBN 0-909190-12-7)

Frequently Prescribed And Abused Drugs: Their Indications, Efficacy, and Rational Prescribing

. . . edited by Sidney Cohen, Charles Buchwald, Joel Solomon, James Callahan, and Daniel Katz

This volume is an effort to provide up-to-date information on the medicinal agents that are being diverted for other than therapeutic purposes. It is addressed to physicians who may be called upon to prescribe psychotropic medication, and special consideration is given to prescribing for children, adolescents, the elderly, and the substance-abusing patient, as well as for patients with such complaints as sleep disorders, anxiety, pain, obesity, and depression. Chapters are devoted to drug use and the prescribing physician, psychotropic drug interactions, the meaning and psychotropic drug treatment of anxiety, prescription of stimulants and anorectics, and the prescription of hypnotic drugs.

(Haworth Press, 28 East 22 Street, New York, NY 10010, 1982. 128p. $20. ISBN 0-86656-115-3)

Other Books

Fetal Alcohol Syndrome: Volume II: Human Studies — Abel, Ernest L. (ed). CRC Press, Boca Raton, 1982. Screening for alcohol-related problems in obstetric and gynecologic patients: alcohol, sexuality, and reproductive dysfunction in women: maternal alcohol use during pregnancy: alcohol embryopathy: epidemiology of alcohol-related birth defects: relationship of children's behavior to maternal alcohol consumption: sleep EEG in newborns of mothers using alcohol. Index. 189p. $78.68.

Heroin and Politicians: The Failure of Public Policy To Control Addiction in America — Bellis, David J. Greenwood Press, Westport, 1981. Formulating heroin-control policy: heroin addiction treatment and its outcome. Figures, index, tables. 239p. $27.50.

Alcohol and the GI Tract — Leevy, Carroll M. (ed). Clinics in Gastroenterology, May 1981. Influence of ethanol on intestinal absorption: immune reactions and the digestive system: alcoholic liver disease: esophageal lesions in the alcoholic: alcoholic gastritis: alcoholic pancreatitis: alcoholic hepatitis: alcoholic cirrhosis: primary hepatic cancer in alcoholics: pancreatic cancer: alcohol and drug interactions in injury to the digestive tract. Index. 241p.

Drug Development, Regulatory Assessment, and Postmarking Surveillance — Wardell, William M., and Velo, Giampaolo (eds). Plenum Press, New York, 1981. NATO Advanced Study Institute, held Oct 12-13, 1980 in Erice, Sicily. Index. 356p.

Drug Dependence and Alcoholism — Schecter, Arnold J. (ed). Plenum Press, New York, 1981. Vol 1: Biomedical Issues, Vol 2: Social and Behavioral Issues. Proceedings of the 5th National Drug Abuse Conference, held in Seattle, April 3-8, 1978. Index. Two volumes. $47.50.

Drug Dependent Patients: Treatment and Research — Craig, Robert J., and Baker, Stewart L. (eds). Charles C. Thomas, Springfield, 1982. Treatment modalities: assessments: outcome. Index. 397p.

Teaching About Alcohol: Concepts, Methods, and Classroom Activities — Finn, Peter, and O'Gorman, Patricia A. Allyn and Bacon, Boston, 1981. Goals and objectives: primary prevention in alcohol education: alcohol and youth: teaching methods: working with parents and the community: instructional activities. Glossary, index. 241p. $23.50.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

23rd Institute on Addiction Studies — July 18-23, Hamilton, Ontario. Information: Karl N. Burden, course director, Alcohol and Drug Concerns Inc, 15 Gervais Drive, Suite 603, Don Mills, ON M3C 1Y8.

Summer Course in Addictions — July 19-23, Toronto, Ontario. Information: School for Addiction Studies, 8 May Street, Toronto, ON M4W 2Y1.

Workshop on Evaluation Research in the Field of Addictions — Sept 8-9, Regina, Saskatchewan. Information: Brian Rush, Addiction Research Foundation, Research Centre for Regional Programs, University of Western Ontario, London, ON N6A 3K7.

Early Recognition and Management of Health Problems in the Workplace — Sept 27, Oct 28, Nov 25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Road, Toronto, ON M4G 3Z1.

Detox Training Programs (Non-Medical) — Sept 27-Oct 1, Oct 25-29, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

American Society of Criminology — Nov 4-6, Toronto, Ontario. Information: Harvey C. Horowitz and Associates, 10369 Currycomb Court, Columbia, Maryland 21044.

Medical Device Technology in the '80s — Dec 6-8, Toronto, Ontario. Information: Canadian Association of Manufacturers of Medical Devices (CAMMD), 480 Garyray Drive, Toronto, ON M9L 1P8.

The Management of Employee Assistance Programs — Feb 23-25, 1983, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Road, Toronto, ON M4G 3Z1.

Medic Canada '83 . . . Toward the Year 2000 — May 29-31, 1983, Edmonton, Alberta. Information: Toby Fay Sykes, Medic Canada '83, 480 Garyray Drive, Toronto, ON M9L 1P8.

Fifth World Conference on Smoking and Health — July 10-15, 1983, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, Ontario K1A 0C1.

United States

The Master of Science in Management (MSM) — Cambridge, Massachusetts. Information: Management Division, Lesley College Graduate School, 1627 Massachusetts Avenue, Cambridge, MA 02138.

Workshop on Chemical Dependency and Adolescents — July 11-16, Minneapolis, Minnesota. Information: Mary Simonson, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN.

11th Annual San Diego Summer Alcohol and Drug Studies Program — July 11-16, San Diego, California. Information: Elizabeth Hendrickson, UCSD Extension, X-001, La Jolla, CA 92093.

Communications and The Future — 4th General Assembly of the World Future Society — July 18-22, Washington, DC. Information: Assembly Committee, World Future Society, 4916 St Elmo Avenue, Bethesda, Maryland.

Alcohol and Other Drug Use and Abuse Among Students: An Update for Educators — July 19-23, Plymouth Meeting, Pennsylvania. Information: enrollment secretary, Educational Resource Services, 329 West Main St, Lansdale, PA 19446.

Biomedical Writing — July 19-23, Boston, Massachusetts. Information: Office of Continuing Education, Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02155.

The 14th Annual Nevada Substance Abuse School — July 19-23, Reno, Nevada. Information: Angela L. Alaimo, Bureau of Alcohol and Drug Abuse, 5th Floor Kinkead Building, 505 E King Street, Room 500, Carson City, NV 89710.

Group Seminar on Adolescence and Chemical Abuse — July 19-23, Minneapolis, Minnesota. Information: Mary Simonson, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN 55441-6199.

Support Group Facilitator Training Workshop — July 26-30, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN 55441-6199.

Annual Meeting of International Doctors in Alcoholics Anonymous — July 29-August 1, Des Plaines, Illinois. Information: Lewis K. Reed, MD, information secretary, IDAA, 1950 Volney Road, Youngstown, Ohio 44311.

7th Annual New Jersey Summer School of Alcohol and Drug Abuse Studies — Aug 1-6, New Brunswick, New Jersey. Information: Ronald L. Lester, director, New Jersey Summer School of Alcohol and Drug Abuse Studies, Rutgers University, Smithers Hall, New Brunswick, NJ 08903.

Annual Summer School on Chemical Dependency — Aug 1-13, Minneapolis, Minnesota. Information: Betty Reynolds, Johnson Institute, 10700 Olson Memoiral Hwy, Minneapolis, MN 55441.

Project Charlie, A Drug Abuse Prevention Program-Training Workshop — Aug 9-13, Edina, Minnesota. Information: Project Charlie, 5701 Normandale Road, Edina, MN 55424.

4th Annual Meeting of the National Register of Credentialed Alcoholism and Drug Abuse Counselors, — Aug 15, Long Beach, California. Information: Dr Valle, American International Health Services, 101 North Common St, Lynn, Massachusetts 01902.

The National Association of Alcoholism Counsellors Annual Meeting — Aug 15-18, Long Beach, California. Information: NAAC, 951 S George Mason Drive, Arlington, VA 22204.

Chemical Dependency and Family Recovery Workshop — Aug 15-20, Minneapolis, Minnesota. Information: Mary Simonson, Johnson Institute, 1070 Olson Memorial Hwy, Minneapolis, MN 55441.

Treatment Directors Seminar — Aug 25-27, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN 55441.

The Alcohol and Drug Problems Association of North America 33rd Annual Meeting — Aug 29-Sept 1, Washington, DC. Information: ADPA, 1101 15th St, NW, Suite 204, Washington, DC 20005.

6th Annual Summer Institute of Drug Dependence — Aug 29-Sept 3, Colorado Springs, Colorado. Information: The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Evaluating Alcohol and Drug Programs: Current Methods and Findings — Sept 13-17, Brooklyn Park, Minnesota. Information: Leslie Nyberg, evaluation and research department, Box 11, Center City, Minnesota 55012.

2nd Annual Workshop on Marketing Mental Health and EAP Services — Sept 15-18, Snowmass-Aspen, Colorado. Information: Sara Bilik, Colorado West Regional MH Center, PO Box 1580, Glenwood Springs, CO 81602.

Alcoholism Treatment: Cooperation or Competition — Sept 20-22, La Jolla, California. Information: Naomi Feldman, conference coordinator, 3770 Tansy, San Diego, CA 92121.

5th National Impaired Physician's Conference — Sept 22-25, Portland, Oregon. Information: American Medical Association, department of mental health, 535 N Dearborn, Chicago, Illinois 60610.

The Benzodiazepines Today: Two Decades of Research and Clinical Experience — Oct 8-11, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton Street, San Francisco, CA 94117.

Conference on Alcoholism Treatment Evaluation: Issues and Applications — Oct 14-15, Fort Worth, Texas. Information: Wendy Lipton, Center for Organizational Research and Evaluation Studies, Texas Christian University, PO Box 32874, Fort Worth, TX 76129.

A Spiritual and Communal Gathering — A Jewish Retreat Weekend for Recovering Alcoholics, Chemically Dependent Persons and Significant Others — Oct 15-17, Woodbourne, New York. Information: Sheldon Baron, Registrar, Retreat Weekend, JACS Foundation, Inc, New York Board of Rabbis, 10 East 73rd St, New York, NY 10021.

National Black Alcoholism Council, Inc 4th Annual National Conference — Oct 21-24, San Diego, California. Information: Don Owens, NBAC National Conference Planning Committee, 4208 National Avenue, San Diego, CA 92113.

Annual Postgraduate Course in Clinical Pharmacology, Drug Development and Regulation: 1982 — Oct 25-29, Rochester, New York. Information: William M. Wardell, The University of Rochester Medical Center, department of pharmacology and toxicology, 601 Elmwood Avenue, Rochester, NY, 14642.

11th Annual Meeting of the Association of Labor Management Administrators and Consultants on Alcoholism (ALMACA) — Nov 2-5, Philadelphia, Pennsylvania. Information: ALMACA, 1800 N Kent St, Suite 907, Arlington, Virginia 22209.

Anorexia Nervosa: Causes and Cures — Nov 3, New Hyde Park, New York. Information: Ann J. Boehme, continuing education coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Alcoholism: Culture and Treatment: Comparative Perspectives from Europe and America — Nov 4-6, Farmington, Connecticut. Information: Margie Meadows, administrative assistant, department of psychiatry, University of Connecticut Health Center, Farmington, CT 06032.

Women In Crisis, Inc 4th Annual Conference — Nov 10-13, New York, New York. Information: Women In Crisis, Inc, 37 Union Square West, New York, NY 10001.

An International Perspective on Substance Abuse: The Problem, Its Treatment, and Medical Education — Nov 15-19, Oakland, California. Information: Dr Charles Buchwald, conference coordinator, Downstate Medical Center, 450 Clarkson Ave — Box 129, Brooklyn, New York 11203.

7th Southeastern Conference on Alcohol and Drug Abuse "SECAD" — Dec 1-5, Atlanta, Georgia. Information: Barbara Turner, conference coordinator, "SECAD/7," Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree-Dunwoody Road — Suite 170, Atlanta, GA 30342.

7th World Conference of Therapeutic Communities — May 8-13, 1983, Chicago, Illinois. Information: Donna Gleixner, Gateway Houses Foundation, Inc, 624 S Michigan Avenue, Chicago, IL 60605.

Scholarly Communication Around The World — The 27th Annual Conference of the Council of Biology Editors, The 3rd International Conference of Scientific Editors, and The 5th Annual Meeting of the Society for Scholarly Publishing — May 15-20, 1983, Philadelphia, Pennsylvania. Information: 1983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Service, 2100 Arch Street, Philadelphia, PA 19103.

Abroad

Second Biennial AU School of Justice Institute on Juvenile Justice — July 11-30, London, England. Information: Dean Richard A. Myren, director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

1982 Summer School on Alcohol Problems — Aug 14-20, York England. Information: Jane Stott, course coordinator, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London, England SE5 8AZ.

11th International Conference on Health Education — Aug 15-20, Hobart, Tasmania, Australia. Information: Joy Faldt, Australian Society of Health Educators, PO Box 818, Fortitude Valley, Queensland, Australia 4006.

Working With Problem Drinking — Aug 23-27, York, England. Information: Jane Scott, course coordinator, Alcohol Education Centre, 99 Denmark Hill, The Maudsley Hospital, London, England SE5 8AZ.

4th World Congress for the Prevention of Alcohol Problems, Alcoholism and Drug Dependency — Aug 29-Sept 2, Nairobi, Kenya. Information: ICPA — International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St NW, Washington, DC 20012.

33rd International Congress on Alcoholism and Drug Dependence — Oct 9-15, Tangier, Morocco. Information: Archer Tongue, International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

Influence of Environment on Man — Nov 17-20, Vienna, Austria. Information: Secretariat Brussels, rue E Bouillot 61 Box 11, B-1060 Brussels, Belgium.

2nd International Congress on Drugs and Alcohol — Dec 18-22, 1983, Tel Aviv, Israel. Information: Judge Amnon Carmi, chairman, organizing committee, 2nd International Congress on Drugs and Alcohol, PO Box 394, Tel Aviv 61003, Israel.

7th World Congress of Psychiatry — July 11-16, 1983, Vienna, Austria. Information: Congress Team International, PO Box 9, A1095 Vienna, Austria.

The Journal

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Advertising Rates
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
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Circulation: 15,094

(Ontario, 11,580; other provinces, 815; USA, 1,979; foreign, 720) Bulk, 3,700, Media, 1,273

Single Subscription Rates
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Other Canadian Residents $12 per year
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ISSN 0044-6203 Printed in Canada

A drug, a multinational, and the Third World

By Richard Starks

TORONTO — To multinational corporations, the Third World market must often seem like an easy mark — especially if they are selling, say, powdered milk, high-tar tobacco, or drugs and medicines that are either banned or restricted in the industrialized West. Regulations and government controls are limited; and in the case of drugs, sales can often be made over the counter instead of by prescription only.

Inevitably, the multinationals have been boosting their marketing efforts in the developing nations, and as a result they have (equally inevitably) been coming under increasing fire. In particular, the multinational drug companies have been attacked for pushing psychotropics: to their critics, there is something inherently wrong in promoting drugs like Valium or Librium in countries where the main problems are epidemics and malnutrition.

Power & muscle

A lot of the criticism is based on ideology or political philosophy, or it is simply a knee-jerk rejection of the power and muscle that the heavyweight multinationals are able to throw around. But once in a while, a case comes to light, which indicates that maybe the drug multinationals do, after all, deserve their bad-boy image.

One such case, which has attracted a lot of public attention, involves Lomotil, (diphenoxylate hydrochloride) a best-selling anti-diarrheal produced and marketed by the United States-based drug giant, G.D. Searle & Co.

The story of Lomotil, and the controversy over its marketing in Third-World countries, is related in a new book called *Drug Diplomacy*, written by Charles Medawar and Barbara Freese, and published by Social Audit Ltd of London, England. It's a story that is all too familiar to those who dislike the drug manufacturers, and not familiar enough to those who think the industry can do no wrong.

Public interest

Lomotil is a non-essential, pharmacologically-reputable drug. Its active ingredient is diphenoxylate, a synthetic relative of opium; it also contains atropine in sub-therapeutic doses to reduce the risk of addiction or abuse.

Social Audit (an independent, non-profit group that has reported and campaigned on a number of "public interest issues" since its founding in 1972) first became concerned about the drug primarily because in Searle's home market, the US, Lomotil is required by the Food and Drug Administration to be contraindicated for children less than two years old — yet in some of Searle's Third-World markets it was being recommended for infants only a few months old.

In addition, the drug is available in the developed West only by prescription, but in the Third World it is freely sold. Also, the drug has a low therapeutic margin, meaning that the therapeutic dose is close to the toxic dose.

The result was that, in the Third World, Lomotil was potentially dangerous, especially to infants.

Social Audit tried to raise these concerns with Searle's United Kingdom subsidiary, but received no response from the company. It therefore printed up a four-page leaflet, which called into question the value and safety of Lomotil. The leaflet drew on a selection of medical reports and journals in which Lomotil, when administered to infants, was described as "dangerous," "hazardous," "unwarranted," and a "cause of serious poisoning."

The leaflet was professionally laid out to look like one of the promotional brochures that drug companies regularly send to doctors. It was designed to attract publicity. And it did.

It also attracted a response from Searle — not from the company's UK subsidiary, but from headquarters in Chicago, Illinois.

Searle's Vice-President of Public Affairs, and two of its big-gun scientists, were sent to London to meet with Social Audit, to defuse the criticism, and to discredit the four-page leaflet (which Searle denounced as "seriously inaccurate and misleading").

The meeting in London went nowhere, but it did lead to an exchange of letters, several trans-Atlantic phone calls, and a more open discussion about Lomotil.

The defence

Searle claimed that, in the US, Lomotil was contraindicated for children less than two years old only because the company had never sought approval for the use of the drug among children that young. In Drug Diplomacy, this claim is shown to be false.

In addition, Searle based the defence of its drug mainly on eight research papers, which supposedly demonstrated the unquestionable value of Lomotil. The company also summarized the findings in glowing terms to create a more favorable impression.

However, Drug Diplomacy effectively demolishes the validity of all eight research studies, showing that each of them has serious deficiencies that make it either meaningless or misleading.

Perhaps most devastating of all is that, when the data of the largest study are rearranged, they show that, among the hospitalized patients who were tested, the mortality rate was significantly higher in the group that received Lomotil than it was in the group that did not (2.25% vs 0.70%).

Claims valid

Another meeting was set between Searle and Social Audit, but before it took place, Searle sent word that it was changing its position. It still maintained that the evidence to support its Lomotil claims was valid, and reaffirmed its conviction that Lomotil is safe and effective in both adults and children. However, it also said it was changing its labelling in all Third-World countries to indicate clearly that Lomotil should not be used in children under the age of two.

It was a peculiar position to adopt, since, as the authors of Drug Diplomacy point out, it meant the company was "emphatically claiming that the scientific evidence it offered supported the very position it was about to abandon."

A victory

It's possible to see the change in labelling as a victory of sorts for Social Audit. But that was never really the issue. It was never a question of who would win and who would lose; instead, it was a question of how responsible are the drug multinationals and how sound is their attitude to Third-World markets.

Say authors Medawar and Freese: "Searle was not entitled to convince itself — let alone others — that Lomotil for children was either effective or safe. The company did this on the strength of a handful of studies whose relevance is doubtful and whose overall conduct was conspicuously poor. Searle allowed bad information to pass for good and was allowed to get away with it."

An example

And they ask: "Why should this be an isolated example?"

Searle is a major company in its industry and there is little reason to assume it is unique. The other companies have similar research, disclosure, and marketing practices.

"The companies concerned invariably defend such practices — not least to themselves — on the grounds that their responsibilities are defined by the law of the countries in which they operate.

"The argument is as puny as the laws in question."

LOMOTIL® ℗ *Searle*

Diphenoxylate HCl ***Antidiarrheal***

Pharmacology: The mode of action of diphenoxylate in the bowel is similar to that of morphine and related drugs. Gastrointestinal propulsion is inhibited through a direct action on the smooth muscle, resulting in a decrease in peristaltic action and a consequent increase in transit time.

Indications: As an adjunct in the management of diarrhea.

Warnings: Keep out of the reach of children since accidental overdose may cause severe or even fatal respiratory depression. The use of diphenoxylate in children under 2 years of age is not recommended.

The use of diphenoxylate during pregnancy, lactation or in women of childbearing age requires that the potential benefits of the drug be weighed against any possible hazard to the mother and child. Effects of diphenoxylate may be evident in the infants of nursing mothers taking the drug since it is excreted in breast milk.

Precautions: Use diphenoxylate with extreme caution in patients with cirrhosis and other advanced hepatic disease and in all patients with abnormal liver function tests since hepatic coma may be precipitated.

Diphenoxylate n of barbiturates, tranquilizers and a it should be closely observed when thes omitantly.

Because its che at of pethidine, the concurrent use of d itors may, in theory, precipitate hypertensi

Although no add served in patients receiving recom ne, addiction to (dependency ible at high dosage. Th ld not be exceeded. E similarity of diphenoxyl potential, diphenoxyla caution to patients wh known to be addiction-p t they may increase the

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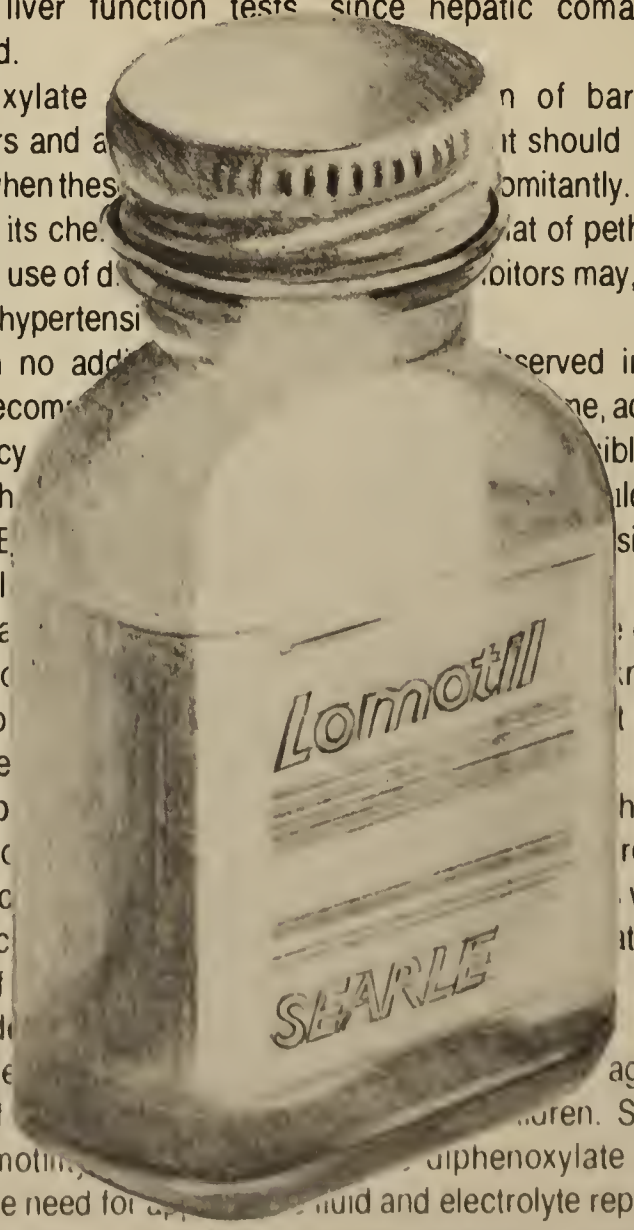


Text from Compendium of Pharmaceuticals and Specialties '82, Toronto.

THE BACK PAGE

Vol. 11 No. 8 2nd Class Mail Reg No. 2776 TORONTO August 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Challenge to Sobell work will have broad impact says review group chief

By Karin Maltby

TORONTO — Criticism by a team of California investigators of controlled drinking research done more than 10 years ago will have broad and direct implications for the entire scientific community.

"I think the story is more for the future than for the past," says Bernard Dickens, PhD, LLD, the University of Toronto law professor named chairman of an independent review committee that will examine the case.

Under attack are husband and wife Mark and Linda Sobell who did the work in the early 1970s in the United States. The two psychologists joined the Addiction Research Foundation (ARF) here in 1980.

Their research purported to show that gamma alcoholics can be trained as controlled drinkers. (A gamma alcoholic, as defined by E.M. Jellinek, is physically dependent on alcohol, and has withdrawal symptoms when alcohol is not consumed.)

The California investigators are challenging the Sobells' claim.

Whatever the review committee finds, says Dr Dickens, "the lesson is for the innocent as well as for the guilty.

"It may be that the fault in this circumstance is in the research technology of the critics, not in those who initially did the study," he told **The Journal**.

In future, "investigators will have to understand they're liable to be questioned not only as to their methodology, but as to their integrity.

"It has to be understood that those who undertake scientific research, which is unlikely to be repeated, or even replicable, have to be prepared to face this sort of question. And this is the warning for all of those engaged in any research."

Dr Dickens said the committee expects to present its findings to ARF President Joan Marshman in the fall.

The Sobell matter was brought to public attention early last month when galleys of an article to be published in the July 9 issue of the prestigious journal *Science*, became available from both the Washington, DC, headquarters of the American Association for the Advancement of Science, publishers of the journal, and the article's authors, Mary Pendery, PhD, Irving Maltzman, PhD, and L. Jolyon West, MD.

The article is entitled Controlled Drinking By Alcoholics? New Findings and a Reevaluation of a Major Affirmative Study.

The Sobells' project, which employed a technique known as Individualized Behavior Therapy for Alcoholics, or IBT, was considered to be breakthrough research.

It involved an unprecedented two-year follow-up of patients trained as controlled drinkers, patients treated with abstinence therapy, and both groups' controls. It presented a contrasting and controversial alternative to the abstinence therapy traditionally recommended for gamma alcoholics.

It has been widely cited in scientific journals and in articles co-authored by the Sobells, and was published in their book *Behavioral Treatment of Alcohol Problems*. In addition, the team contributed chapters to the scientific literature during the 1970s that reported the largely-successful outcomes of treatment of their patients.

Pendery et al, however, report that most of the 20 subjects trained by the Sobells to control their drinking failed to do so from the outset. Moreover, they suggest a subsequent, independent, third-year follow-up of those same patients by Caddy et all does not bear scrutiny.

Publication of the critical report was not unexpected.

The Sobells knew the Pendery group was conducting an investigation as early as the mid-1970s says Alan Marlatt, PhD, a psycho-

(See — Conflicting — page 3)

Linda and Mark Sobell: Their work has been widely cited.

Pendery: IBT study does not bear scrutiny.

Sobell statement:

'We are confident'

TORONTO — Psychologists Mark and Linda Sobell have issued a written statement to the media following charges by a California group that their early research on controlled drinking does not bear scientific scrutiny.

The Sobells, now at the Addiction Research Foundation here, have refused to comment on the allegations pending the outcome of an external review committee that will examine both their work and the allegations of their critics.

The committee expects to report in the fall.

Their statement follows:

"Our publications on the study (Individualized Behavior Therapy for Alcoholics) are a full and accurate account of the research we conducted and the findings we observed during our work in California, and we categorically affirm the integrity of our research.

"Earlier this year, when we first learned of a pending article in *Science* purporting to refute this study, we requested that an impartial, objective inquiry into this matter be conducted by external reviewers. As a result of our request, an External Review Committee has been established. Pertinent documentation and other evidence related to the study have been turned over to the Committee. The Committee is independent of ourselves and of the Addiction Research Foundation of Ontario, where we are now employed.

"We are confident that on the basis of the impartial investigation, the integrity of our research will be completely vindicated.

"Until the conclusion of the independent review, based upon the advice of legal counsel, we will not discuss this matter further. After the review has been completed, we will comment on these issues."

Drs Mark and Linda Sobell

US drug strategy on way: Turner

By Harvey McConnell

WASHINGTON — A stem in the flow of illegal drugs entering the United States, and a reduction in demand for drugs, are the major objectives of US President Ronald Reagan's administration.

Carlton Turner, chief adviser to the White House on drug abuse policy, told **The Journal**: "You are going to see some very interesting things occurring this fall" following publication of the Federal Strategy on Drugs.

Turner: Interesting things in fall.

Dr Turner said President Reagan wants new ideas and new approaches to the drug abuse problem, and had indicated it was time to "take down the surrender flag and run up the battle flag" on drug issues.

Dr Turner said this does not mean there will be massive infusion of federal money into programs.

"I think the appropriate way is to use all of the resources that are available to the federal government that have been held in abeyance and are now going to be resurrected, such as the forfeiture laws, the laws on bails, the reform of the criminal code.

"It's the kind of thing that when they get a big dealer, then that dealer is going to serve some time."

Dr Turner said many people consider treatment is the ultimate goal; he believes "the ultimate is to prevent people from getting involved.

"You are going to see more international initiatives, more high-level international approaches to these things, because we must reduce the flow of drugs into this country.

"At the same time, we must also provide a situation in this country where the demand for drugs is greatly reduced."

On the forthcoming Federal Strategy document, Dr Turner said many people forget there is a difference between a strategy and a policy. The need first is for a strategy and then for development of policies based on the strategy.

The support he has already received from the various federal agencies indicates to him "our program will be a very successful program."

Dr Turner said there is no intention "to say the hell with treatment."

An example, he said, is the effort being made by his office to persuade pharmaceutical companies to produce "orphan drugs" — drugs with a very low profit margin and needed by a minority of people — for use in the drug abuse field. So far, companies and federal agencies involved have been cooperative, he said.

About people with alcohol problems, Dr Turner said his office will look at education and prevention "not in the sense of covering people from the cradle to the grave" but for the group in which there is the largest potential influence: young people under the age of 18.

"We want to help them to be able to resist pressure to use any kind of drug until they have matured enough to make sure they can live a productive live life without having the problems of abuse."

Dr Turner predicted there will be many complaints when the Federal Strategy is released because resources are limited "and you can't cover the whole spectrum of what might be of interest to everyone."

INSIDE

NEWS

Briefly...

Morrison award

TORONTO — An influential group of scientists here has honored Robert C. Petersen, former United States National Institute on Drug Abuse (NIDA) official, with a newly-created award. The Michael J. Morrison Award, was presented to Dr Petersen at the annual meeting here of the Committee on Problems of Drug Dependence. It signifies excellence and creativity in research administration.

Cable TV ad ban

OTTAWA — The Attorney-General of Saskatchewan has announced plans to delete cable-transmitted alcohol beverage advertising from United States televison stations. Alcohol beverage advertising in the province has long been illegal, and a proposal to substitute US commercials with provincial health promotion material involves technical difficulties which are still under discussions. Once problems are ironed out, approval for the substitute programming will be sought from the CRTC (Canadian Radio-Television Telecommunications Commission), before Saskatchewan can proclaim the appropriate section under its Liquor Control legisation.

'Disco' drugs a threat

CHICAGO — The federal government should intervene before "disco drugs" cause death, warns a Purdue University pharmacology professor. "It has been reported that these compounds (butyl nitrite) are even sprayed out over disco floors from ceiling spray units to rev up the dancers," Roger Maickel said. Butyl nitrite, sometimes prescribed to relieve arterial spasms, is also sold as an aphrodesiac in head shops and through mail-order ads under the trade names Rush, Climax, and Discorama.

OHIP hit

TORONTO — Ontario's Health Insurance Plan, (OHIP) is being taken for thousands of dollars a year by people who fake illness to get prescription drugs from more than one physician, says a senior Toronto police officer. The situation has become so serious that a special police team has been formed to work with the OHIP and federal officals to fight what is known as "double-doctoring." Hydrocodone-based cough syrups are among the drugs most-commonly sought for non-medical purposes.

Smoker ignites

TORONTO — A 61-year-old rooming house resident has painfully discovered alcohol and cigarettes don't mix. When the man sprayed a 75% alcohol bug repellant around his rooms and on his clothes, and then lit a cigarette, his clothes burst into flames. A neighbor doused him with a fire extinguisher but wasn't able to prevent second- and third-degree burns from covering 60% of the man's body. He'd used the spray, police said, to keep cockroaches away while he slept.

CAF money woes prompt move west to Alberta office

By Mark Kearney

TORONTO — The Canadian Addictions Foundation (CAF) will move its head office from Ottawa to Edmonton Oct 1 as a way of improving its financial picture and its efforts to become a stronger organization across Canada.

The CAF will work out of offices provided by the Alberta Alcoholism and Drug Abuse Commission (AADAC), and have access to its resources and staff, Ross Ramsey, the newly re-elected president of the CAF told **The Journal**.

A full-time director for the CAF will be chosen from within the AADAC's ranks by mutual agreement of both organizations, says Mr Ramsey. A secretary will be hired through the CAF, however the salaries of both will be covered by the AADAC.

Mr Ramsey says the move is "a significant step" in the organization's history because the resulting cost savings will allow the CAF to use its existing $70,000 budget to provide more information to its members and the public on problems of addiction and developments in the field.

The decision to establish this relationship with the AADAC was made in June at the CAF annual meeting in Yellowknife, NWT. However, the decision was reached only after the AADAC was assured that other groups throughout the country were also willing to provide help, Mr Ramsey says.

Access to a computer, for example, will be provided by a group in Saskatchewan while the Addiction Research Foundation of Ontario will continue to distribute educational materials for the CAF such as books, audio-visual supplies, and films, he says.

Mr Ramsey estimates the services and staff time provided by AADAC will be equal to $55,000 to $60,000 a year, money that up to now would have had to be provided by the CAF.

The agreement with the AADAC will run until Nov 1, 1985, when the head office will move back to Ottawa.

Although the CAF began taking advocacy positions last fall (opposing the federal government's plans to decriminalize marijuana), Mr Ramsey doesn't believe the move from Ottawa will hurt the organization's lobby power.

Most of the lobbying up to now has been on a local or provincial level anyway, he says, and should remain effective even with the new office in Edmonton. The CAF will still maintain a mailing address in Ottawa.

Until October, Vernon Lang, a private consultant, will serve in his present position as part-time executive director. Mr Lang's contract expires at that time, but he may continue to be involved in the CAF on a fee-for-service basis, Mr Ramsey says.

Having established "a strategy to pay some bills," the CAF will make plans to become a stronger, and more active and dynamic organization, Mr Ramsey says.

The meeting in Yellowknife has laid the foundations of a new structure for the next three years, but it's not an end in itself, he says. The CAF now has about 900 members who will be paying annual fees of $15, up from the previous $10.

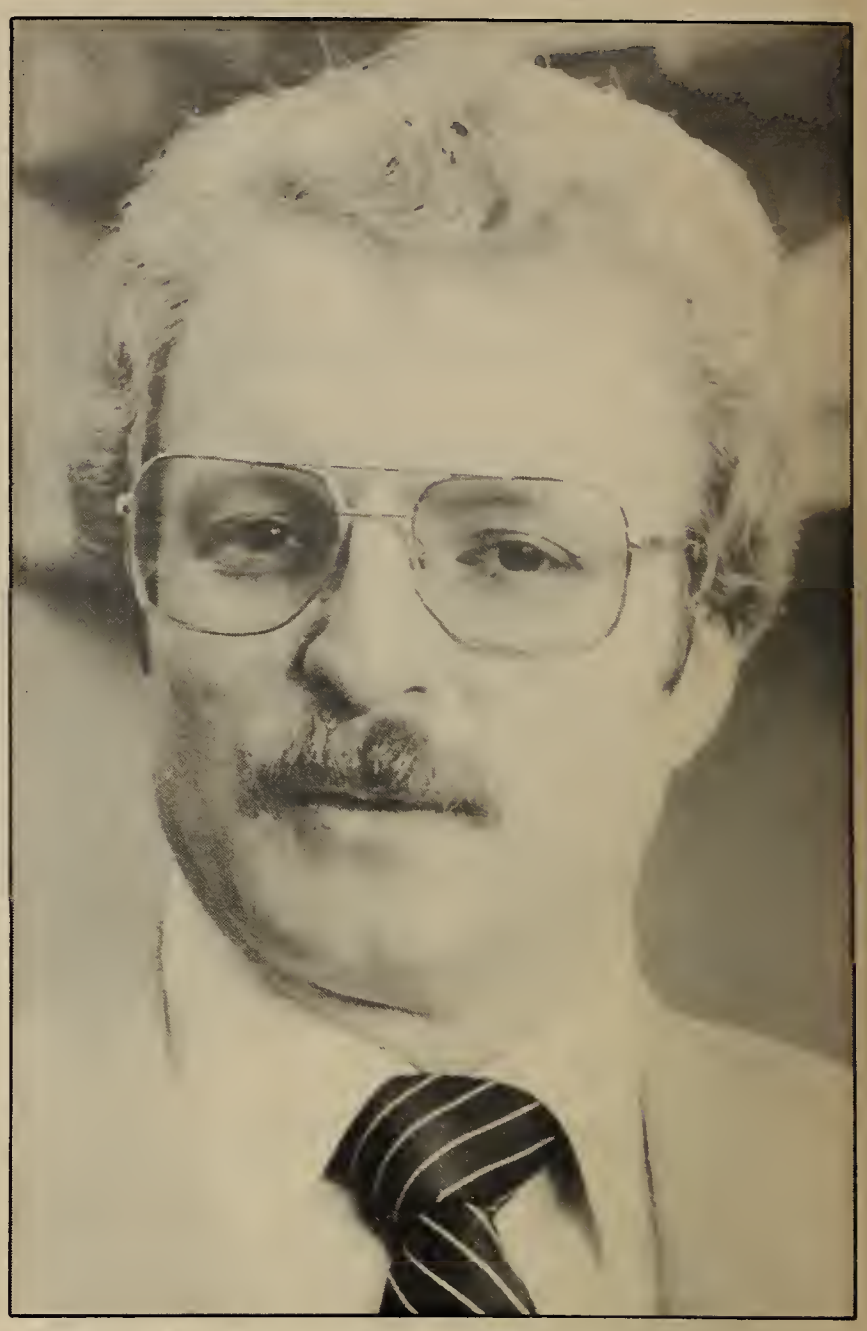
The next meeting, scheduled for mid-December in Toronto, will look at larger fund-raising plans and probably set up various groups and committees to deal with forthcoming issues.

One thing Mr Ramsey wants is to contact people throughout Canada who can meet to discuss issues and make the public aware of problems with addictions. They may also help to improve the CAF's financial status: "We're looking for key Canadians who can connect to businesses to open doors for us."

Although the organization has had a financially-troubled past, Mr Ramsey says his discussions with officials of other organizations has shown him this problem is not exclusive to the CAF.

Although the CAF receives a federal grant of $39,000 and is expecting the same next year, Mr Ramsey has expressed interest in cutting ties with the government as the organization's financial position becomes stronger.

Mr Ramsey says that while national and provincial organizations with government money can accomplish much, they are usually, in the long run, linked in some way to government and its policy.



Ramsey: CAF move west is a significant step.

Middle-class seeking anti-cocaine therapy

SANTA MONICA, CA — An increasing number of middle-class cocaine users are seeking help from a clinic here which for the past eight years has drawn most of its clients from street drug users.

"Many of these cocaine users drive up in their nice cars, and they are nicely dressed, and just walk in," much to the surprise of Michael Casey, director of the clinic, New Start.

"We are seeing people who even just a year or so ago would not have had any interest at all in being involved with our sort of agency. They would have sought out a doctor and gone the medication route."

They "realize they have reached the threshhold of pain, or are burning out themselves, their relatives, and friends. They want to change."

The clinic is drug-free and the basis of treatment is therapy.

Mr Casey: "Some of these people may not want to eliminate cocaine completely from their lives, but we have discovered that counselling does lead to increased awareness about the effects of cocaine and a decrease in their usage. Many others cut out cocaine altogether, realizing they can't be recreational users after really being strung out in the past."

Mr Casey was speaking at the Cocaine Today conference held here recently. (See pages 7, 10, 11, 16, and The Journal, July.)

Cocaine scandal hits US Congress

WASHINGTON — A United States Federal Grand Jury here is investigating claims that a drug ring with a network of Capitol Hill legislative aides supplied cocaine to some Congressmen and staff members for other legislators.

At the same time, Representative Robert Dornan, a member of the House of Representatives select committee on narcotic abuse and control, says investigators have told him six or so members of Congress are cocaine users.

Representative Dornan allowed a Washington, DC, policeman to pose as one of his aides during the investigation into drug dealing in and around the capitol.

Bruce Johnson, a Washington television reporter, first reported that city and federal agents were investigating drug dealing on Capitol Hill. He told **The Journal**, police are trying to get their hands on cheques which bear the signatures of prominent Washingtonians and are made out to one of those arrested as a dealer.

Mr Johnson said he had seen some of the cheques.

It was after Mr Johnson's reports appeared that the government and city admitted an investigation has been going on for some time and that arrests had been made in April. One of those arrested is now assisting investigators and is in protective custody.

Mr Johnson's reports came out after the joint federal and District of Columbia police task force began running into Congressional flack.

The Federal Bureau of Investigation has now launched its own investigation into the situation.

Representative Dornan said allegations of cocaine use among some Congressmen should be investigated because they are among the legislators who pass laws that determine the legal status of such drugs as cocaine.

"It would be shocking if this part of the investigation is swept under the rug," he said.

NEWS

Integrity, scientific method are issues

Conflicting data arouse scientific community

(from page 1)
logist at the department of psychology, University of Washington, Seattle.

ARF President Dr Marshman heard rumors in February of this year. In May, she asked Dr Dickens to chair the external review committee. She says it was set up at the Sobells' request.

Linda and Mark Sobell have refused to make public comments until after the review committee has completed its task, but they have issued a brief, written statement to the media. (See page 1.)

Also, their lawyer, Edgar Brenner of Washington, DC, told **The Journal**: "(They) are confident they're going to be completely vindicated in the eyes of their scientific colleagues. They completely stand behind their study."

Mr Brenner will not discuss the subject of legal action by the Sobells at this time, but says he was retained by them when they learned of the impending publication of the *Science* article. He says they chose a Washington lawyer "because *Science* is published in Washington."

For Dr Pendery, a psychologist at the Veterans Administration Medical Center in San Diego, Ca, the basic issue is: "Either the Sobells did what they said they did, and found what they said they found, or they didn't do what they said they did, and they didn't find what they said they found.

"We have two sets of data here, two sets of findings," she told **The Journal**.

Her co-author, Dr Maltzman, professor and former chairman of the psychology department at the University of California, Los Angeles (UCLA), confirmed to **The Journal** his earlier statement to *The New York Times*, that "it's fraud."

The mandate of the review committee? To conduct a thorough review of the original research by the Sobells, and of their follow-up studies; to consider the Pendery et al criticism, and other relevant material; and to allow the Sobells an opportunity for a rebuttal. (The rebuttal to the Pendery study was supplied prior to the first meeting of the committee, which was scheduled to be held on July 20.)

In addition to Dr Dickens, committee members are Dr Anthony Doob, PhD, director, Centre of Criminology, University of Toronto; Dr Harold Warwick, MD, professor emeritus, faculty of medicine, and retired vice-president, Health Sciences, University of Western Ontario; and Dr William Winegard, PhD, former president, University of Guelph (Ont), and past chairman of the Ontario Council on University Affairs.

Dr Dickens said the essence of the issue, as he sees it, is the question of whether the Sobells were not pursuing scientific methodology, and whether they arrived at their conclusions because of their biases.

"Now of course, that's still a problem for Dr Marshman and the ARF, even though it leaves the Sobells in the clear on a charge of 'wilful misrepresentation'."

Joan Marshman, John Macdonald

Dr Dickens stressed the committee will make no recommendations to the ARF. Dr Marshman told **The Journal** she will not anticipate the outcome of the review or comment on action, if any, she might take. "I won't prejudge the committee," she said.

Dr Marshman's view, however, is that "a lot of issues are being confused," and that at least three areas of discussion should be separated.

First, "do the reports in the literature co-authored by the Sobells accurately reflect the procedures they used, and the data collection exercises in which they embarked . . . did they report things the way they really were? The whole question of that area speaks to their integrity."

Second, "if the reports are accurate reflections — was it a well-designed study? Does it hold water scientifically? As far as I'm concerned, that's there in the literature. That was there 10 years ago for the scientific community to make judgements on."

Third, "is controlled drinking a viable treatment for gamma alcoholics? What impact has the Sobells' work had on the world's population of alcoholics?"

Finally, Dr Marshman said, it's important to remember "the world has moved forward, there are a lot of different views being held now that weren't two or three years ago in the treatment of people with alcohol problems."

The IBT study began in 1970 at Patton State Hospital, 70 miles northeast of Los Angeles.

Kenneth Mills (PhD), now a researcher in the alcohol studies department, University of North Carolina, was then a graduate student.

He told **The Journal** that in 1970, both he and Mark Sobell, another graduate student, were asked by Halmuth Schaefer, then staff psychologist at Patton State Hospital, to assist in alcohol treatment studies there.

In the summer of 1971, Mills, Sobell (Mark), and Schaefer published an article, Training Social Drinking as an Alternative to Abstinence, in *Behavior Therapy*. The article covered work at Patton that preceded the IBT study. Dr Mills said he left Patton before completion of the IBT study to pursue other research.

Dr Schaefer, PhD, is now a research specialist for the state department of health, Atascadaro State Hospital, Atascadaro, California.

He would make no comment to **The Journal** about his work with the Sobells at Patton or about the Pendery study.

Mark Sobell's curriculum vitae states he progressed through a series of positions at Patton between 1970 and 1971, culminating in his appointment as assistant director of the alcoholism program. Linda Sobell's last position at Patton was research assistant on the alcohol treatment program.

Both the Sobells were involved in the IBT study. Together with its two-year follow-up, it would become known as the first research treatment program in the US to use explicitly a treatment goal of controlled drinking.

The subjects were 70 male, gamma alcoholics who had voluntarily admitted themselves to

Alan Marlatt, Glenn Caddy

hospital. Four experimental conditions were assigned: a treatment goal of either controlled drinking or abstinence; and within each category, a control group that received only conventional treatment, and an experimental group that received 17 "experimental" sessions, including therapy in a simulated "bar."

The 20 "experimental" subjects who received controlled drinking training were given wallet-sized cards at the conclusion of their treatment. Signed by Mark Sobell, the cards contained individualized drinking instructions. Their controls were 20 subjects who sought a treatment goal of controlled drinking but were given conventional therapy, (Alcoholics Anonymous, for example).

On discharge, both groups were followed up for a two-year period by Linda Sobell.

In their 1978 book, *Behavioral Treatment of Alcohol Problems*, the Sobells reported that every subject, and as many collateral information sources as possible, were contacted every four weeks throughout the entire two-year period.

Data at the end of the follow-up were presented for all of the controlled drinking subjects and all but one of the abstinence subjects. It constituted "the highest documented follow-up rate in the alcoholism literature," they said.

A radical and intensive experiment had been conducted to test a specific approach to the behavioral treatment of alcohol problems, they said, "and the experiment was successful.

"In particular, only subjects treated by IBT with a goal of controlled drinking successfully engaged in a substantial amount of limited, nonproblem drinking during the two years of follow-up, and those subjects also had more abstinent days than subjects in any other group. These findings remain the most important results of the IBT study," they reported.

An independent third-year follow-up of the Sobells' patients was led by Glenn Caddy, PhD, and essentially confirmed the Sobells' results.

Dr Caddy, now at the department of psychology, Nova University, Fort Lauderdale, Fl, would make no comment to **The Journal** pending his own review of the Pendery article.

Some time after the Sobells left Patton State Hospital, Drs Pendery and Maltzman decided there was a need to do their own investigation. Dr Pendery say that was at least partly because some of her own patients were asking for controlled drinking training.

They maintain their investigation was hindered in at least two ways; there was difficulty in securing funds, and difficulty in gaining access to the names of the Sobells' subjects.

The investigation would take until 1981 to complete. In addition to examining both the Sobell and the Caddy findings, the Pendery group continued to follow the controlled drinking group for 10 years. (Dr West, chairman of the psychiatry department at the UCLA School of Medicine, joined the team in the late 70s.)

Their article in *Science* claims: "The results of our independent follow-up of the same subjects, based on official records, affidavits, and interviews, stands in marked contrast to the favorable controlled drinking outcomes reported by the Sobells and Caddy et al.

"Our follow-up revealed no evidence that gamma alcoholics had acquired the ability to engage in controlled drinking safely after being treated in the experimental program."

The Pendery study has been criticized by some scientists contacted by **The Journal** for not including follow-up on the three other groups in the Sobell study. Others, however, consider it is not a relevant issue.

Dr Pendery agrees. She maintains the issues are first, contradictory findings on the controlled drinking subjects, and second, the validity of controlled drinking as an alternative to abstinence.

And to critics who may question the relevance of a follow-up study that looks at work done a decade ago, Dr Maltzman says: "Our evidence is not simply based upon the verbal reports of these patients. If that's all we had, it would be a tempest in a teapot. We have the hospital records, police records, completely contrary, contradicting the statements of the Sobells."

Dr Marlatt, a professional colleague of the Sobells, has attempted to put the issue of contradictory findings into perspective.

In a May 27 letter to Dr Ray Hodgson of the Addiction Research Unit of the Maudsley Hospital, London, he wrote: "It is as though the data were being viewed through opposite ends of the telescope by both groups of investigators: Pendery et al magnify the negative outcomes during the first year (of the follow-up), and the Sobells focus on the positive outcomes, especially in the second year."

He continues: "It looks to me as though both the Sobells and Pendery et al are both 'right' in this matter, depending on the perspective one takes. One group looks at the overall rate of success for the patients, while the other group looks at the indices of specific failure.

"If this were the only problem, then the whole matter might be resolved by an attempt to replicate the original study, and/or by bringing the matter up for public discussions and debate.

"This is not the tactic taken by Pendery and her colleagues, however . . . And that seems wrong to me."

(Dr Marlatt's letter was copied to the Sobells; they gave a copy to **The Journal**.)

Official ARF involvement in the controversy began with the recent establishment of the review committee. However, former ARF President John B. Macdonald told **The Journal** he had heard of the pending publication of the Pendery et al study in June, 1981 from Gordon Bell, founder of the Donwood Institute, a private treatment centre in Toronto.

Dr Macdonald, now chairman of the board of the ARF, says he was not prepared to take any action until he saw the published article. He did not discuss the matter with the Sobells.

Dr Bell had met Dr Pendery in Sept, 1980. Impressed with her preliminary work, he initiated a drive among his recovered patients to help finance the completion of her study.

"I became quite amazed at the discrepancy between what she was reporting, and what had been reported by the Sobells," he told **The Journal**.

Dr Bell also met Ray Miller, one of the Sobells' patients, who had become involved with a group called the Alcoholism Truth Committee. This group, Dr Pendery says, helped her by supplying consent forms for the release of official hospital and jail records. The 'truth committee' is composed of some of the Sobells' patients at Patton State, and their families and friends, Dr Pendery says.

Mary Pendery, Gordon Bell

The Sobells were appointed to the ARF's Clinical Institute in May, 1980: Mark Sobell as Head, Socio-Behavioral Treatment Research, and Linda Sobell, as Head, Behavioral Intervention Research.

In consultation with other ARF research groups, and with their expressed interest in mind, says Dr Marshman, the Sobells proposed the construction of a $12,200 simulated bar in the Clinical Institute. It was completed in March, 1981.

Dr Marshman: "The Sobells knew a line of work they wanted to pursue. They were going to look at the behavior of people drinking alcohol, videotape them, and look at the impact of the videotape on their post-alcohol consumption behavior. This was with a view to formulating an approach to using videotape playback in the treatment context."

To date, the bar setting has not been used by anyone, including the Sobells. Before new research may proceed, a protocol must be approved on scientific and ethical grounds by various ARF commitees.

The Sobells have simply taken longer to submit such a protocol than was originally anticipated, Dr Marshman said.

Dr Dickens looks to the future for the scientific community: "I think there will have to be more reliable techniques for preservation of research data. There will have to be mechanisms to ensure that integrity, as well as competence, are being adequately monitored before a study is undertaken, and why a study is undertaken. There may have to be systems, for example, of spot checks on research data in advance of conclusions being drawn."

(As **The Journal** went to press, the US National Institute on Alcohol Abuse and Alcoholism was considering a formal investigation of the Sobell matter. The NIAAA funded the two-year follow-up portion of the Sobells' IBT study for a sum of $4,900.)

NEWS

Drug-dependent moms expect too much from babies: Finnegan

TORONTO — Drug-dependent mothers appear to have inappropriate and unrealistic expectations of their babies, says a study by psychiatrists at Thomas Jefferson University in Philadelphia.

The study shows 40% of these mothers answered questions incorrectly about "basic developmental milestones" children reach.

The mothers consistently misjudged the ages at which they believed their babies should learn how to walk, talk, and have the physiological maturity for toilet training. They expected such behavior at a much earlier age than the average mother did.

Loretta Finnegan, an associate professor at the university's department of pediatrics who worked on the study, told **The Journal** she was surprised by the results because she expected the drug dependent mothers would have had lower expectations of their children.

The study suggests the mothers may think poorly of themselves because of their drug habits and therefore want their children to be much better people, she explained. It may also indicate a need to look more closely at environmental factors when evaluating the development of these children.

The study tested 30 women who had at least two years of drug abuse with opiates. The average age of the mothers was 28 and they averaged 11 years of education. Dr Finnegan said the researchers were careful to have subjects whose only problem was drug abuse.

The mothers answered 34 questions on such things as how to react to a baby's movements, what to do about a baby's crying, as well as the questions on child development. In addition to the mistakes on the developmental questions, one-third of the mothers incorrectly answered 12 of the other questions.

Dr Finnegan said the researchers will study the babies up to the age of five. Of children folowed-up so far, most seem to be developing normally despite the higher-than-usual expectations of their mothers.

Dr Finnegan was speaking to the meeting here of the Committee on Problems of Drug Dependence.

Finnegan: Surprised by results.

Bingo hall CO levels may be hazardous

LONDON, ONT — High levels of carbon monoxide (CO) in smoke-filled bingo halls can produce symptoms of CO poisoning in players and create hard-to-diagnose admissions to hospital emergency departments, says a London doctor.

A 69-year-old woman was admitted to hospital here because she had been suffering bouts of confusion, dizziness, and chest pain in the preceding two months.

At the time of admission, said physician William Watson in an interview with **The Journal**, "the patient wasn't sure of time or place. She couldn't give us a coherent history, only very basic information. In fact, it was 48 hours before the patient was able to talk coherently."

The woman did not have any detectable disease or illness and wasn't intoxicated. A series of lab tests was done but the only significant finding was that the amount of oxygen in her blood was abnormally low.

Dr Watson placed the patient under observation and waited. By the third day, her symptoms had diminished, and the doctor was able to ask her a series of questions about her health and activities.

It turned out the woman, an avid bingo player who often spent three nights a week at the bingo hall, had been carrying on her playing as usual, despite her symptoms. She was also a heavy smoker.

"The penny dropped," Dr Watson said. "The woman had been suffering from carbon monoxide poisoning."

Dr Watson said few people would show symptoms of poisoning from one exposure, but the risk rises sharply if the person is older, a smoker, and if the exposure is recurrent and spaced closely enough to produce a cumulative effect.

He suspects that inadvertent CO poisoning from exposure to smoke-rich environments is more common than doctors, or the general public, think.

Ottawa deaf to pleas for cannabis info: CODA

TORONTO — The federal government is ignoring requests to provide the public with more information on marijuana and its effects, says the executive vice-president of the Council on Drug Abuse (CODA).

Michael Harrison says there's been virtually no support from the government in launching an education campaign on the subject. It's important that such a campaign is carried out before any changes in drug legislation are made, he said at a recent CODA conference here.

The CODA has provided the government with a survey of students taken last year which shows a majority of them would like more information about the effects of marijuana.

The survey of 1,820 students across Ontario also shows that the majority oppose legalizing marijuana and that present laws and penalties should be strictly enforced, says Mr Harrison.

The survey seems to indicate that students are reachable with "solid information" about drugs, but the federal government has to be more involved, he adds.

Mr Harrison says that despite contacts with Solicitor-General Robert Kaplan requesting government action, all the CODA has received in reply is "arguments about statistics." The CODA has received some more money from the provincial Ministry of Health to do further attitudinal surveys, but that doesn't excuse the federal officials from not taking an active part, he adds.

Norman Panzica, a senior CODA consultant, echoed Mr Harrison's concerns.

"The federal government has $30 million to tell us that we don't waste energy or that we have a great country . . . and yet it doesn't have 50 cents for a commercial on drug problems," Mr Panzica said. "Do we really need a billboard with that heartwarming message 'Canada works.' "

Harrison: Arguments about statistics.

OMA moves to cut tranquillizer scripts

TORONTO — The Ontario Medical Association has launched a "major campaign" against inappropriate prescribing of benzodiazepines.

It is asking its 15,000 members to reassess all patients who have been taking the drugs for more than four weeks, especially those more than 60 years of age.

"Once the reassessments have been done, it may prove beneficial to put the patients on the drug holiday," said Dr Michael Brennan, of London, Ont, chairman of the OMA committee on drugs and pharmacotherapy.

"Benzodiazepines can be useful adjuncts in the short-term management of anxiety, tension, and insomnia as well as alcohol withdrawal and other conditions, but there is also the potential that patients kept on such drugs for extended periods of time may suffer severe adverse effects, including dependency."

In the same week the campaign was announced, results of an Addiction Research Foundation survey showed benzodiazepine use in Ontario has already dropped more than 50% in the last five years, from 13.2% to 8.6% of adults interviewed (**The Journal**, July).

Crossed transactions and the pot laws

By Wayne Howell

Transactional Analysis was somewhat of a fad a decade ago. Like most people, I forgot about transactional analysis when *The Games People Play* slipped off the pop music charts. However, the other day I picked up a little book entitled *Games Alcoholics Play* written by one of Dr Eric Berne's disciples, and once again, immersed myself in the Child/Parent/Adult theory of ego-states, the theory of reciprocal and crossed transactions, and the fanciful little names the TA-ers give to the various games people play.

As I read the book it struck me, for no good reason I can discern, that what transactional analysis had to say about the behavior of individuals can also apply to the behavior of groups, and this might help explain some aspects of our political life.

It occurred to me that it is mainly the Child in us that elects our leaders. The Child electorate wants everything it can get, and more. So we elect Child leaders who are as self-indulgent and reluctant to face reality as we are, which is one of the reasons we now have such serious economic problems. The Parent in us also goes to the ballot box to make sure we get the goodies we deserve, and naughty people who don't deserve them won't get them; welfare bums and the like.

And so the *vox populi* is actually composed of two voices: the *vox infantum* and the *vox parenti*. There is no *vox adultum* to speak of, and this is where the trouble starts. Because from time to time our elected leaders — who, like us, are capable of acting in three ego states — voice adult thoughts, thoughts that are rational and unemotional. But Adult-to-Child or Adult-to-Parent communications don't work because the ego states are not complimentary. These communications result in "crossed transactions" and when those occur we tell the Adult thinker where to get off. Fast.

Curiously enough, I can think of no better way to illustrate this concept than to cite the experience of my fellow columnist in **The Journal**, Richard Gilbert. While wearing his elected-official hat, he suggested that the solution to the Falklands crisis was to give each of the islanders $500,000 on the condition that they leave the islands and let the Argentinians do what they wanted with the inhospitable place. This proposal was so Adult in its humanitarian logic (no lives lost as opposed to what turned out to be close to 1,000) and so Adult in terms of cost-effectiveness ($90 million as opposed to many billions) that people couldn't stand it. The *vox infantum*, wishing to see a real bang-bang, shoot-em-up war from a safe distance was appalled. And the *vox parenti*, wishing to see the naughty "Argies" whipped and sent to bed early, was also thrown into a state of high dudgeon. Letters to the editor came thick and fast, and always the subtext was the same: how dare he voice such thoughts (Adult thoughts) in public; he should know better than to try to communicate with us on that level.

It is not such a big step from a real war to a metaphorical war, the war that our leaders declare from time to time on alcohol and drug abuse. The plan to "decriminalize" marijuana is the equivalent to Gilbert's proposed solution to the Falklands crisis. Decriminalization recognizes current reality and offers an unemotional Adult solution. It admits that marijuana smoking is not going to be stamped out, but refuses to condone the activity as medically sound or socially useful. It is an Adult approach to a continuing problem that produces its own kind of casualties. (Just recently an Ottawa man *and the lawyer who defended him* both had to declare personal bankruptcy after *successfully* fighting a decade-old marijuana charge in the state of Texas.)

Yet, every time this Adult proposal is whispered about legislative halls, the *vox parenti* becomes wildly indignant that marijuana users will no longer be spanked soundly and sent to their rooms. And the *vox infantum* (in this case a minority voice) throws a tantrum because, although it is being allowed to have peaches and cream, the continuing parental admonition "this is going to be bad for you" spoils the fun.

Right from the start all the transactions are crossed. The politicians retreat from the brouhaha their Adult thinking has caused and revert to Parent or Child roles, the only ones the *vox parenti* and the *vox infantum* will allow them to play. Once again, decriminalization is put on "hold."

Until we use our Adult brains to elect our leaders it is highly unlikely that we are going to solve the marijuana problem, let alone our economic problems.

NEWS AND COMMENT

Stereotypes hamper anti-drug progress

Youth and parent groups must shift their thinking

By Harvey McConnell

WASHINGTON — Lingering stereotypes that many youth workers and members of parent groups hold of each other impede effective drug abuse prevention in many communities.

Tom McCarthy, alcohol and drug specialist with the United States National Youth Work Alliance, told its annual conference here the situation is not as contentious as it was several years ago, but the stereotypes linger.

"I think many youth workers have a stereotype of parent groups as right-wing, unreasonable, hard on kids, unsympathetic, and not understanding.

"I think a lot of parent groups have the mistaken stereotype of youth workers as being left-wing, too permissive, and not critical enough of drug use."

The view of the National Youth Work Alliance is that neither group is correct. "Unfortunately, though, in many communities, these stereotypes are preventing youth programs from working as closely together with parent groups as we would like them to.

"After all, the bottom line is helping kids not to get involved with drugs, and helping those who are involved with drugs."

Mr McCarthy said many parent groups are not paying enough attention to adolescent alcohol abuse although they are doing good work in the drug abuse area.

On youth workers, he told **The Journal** he is glad to see an evolution in their attitude to drug use.

"I think in the last decade it was too permissive, and that is also the opinion of the National Youth Work Alliance.

"I think as youth workers learn more about drugs and their effects, and they begin to see the objective controversy being raised about marijuana use, they will be more cautious and have a different attitude toward marijuana use than before."

Many youth workers need to be aware that the marijuana available to adolescents today is much more potent than it was a decade or so ago.

Mr McCarthy said youth workers should become more conversant with how to identify alcohol problems among young people, how to confront them, and how to refer them to treatment if the problem is serious.

At the same time, youth workers should realize alcohol or drug use may be part of the reason an adolescent is a runaway or delinquent or is having difficult with the justice system.

"We would like to see youth workers do more early intervention among adolescents with drug and alcohol problems and to support them while they are in treatment.

"While most youth workers are strong on counselling and helping . . . they need to develop more alcohol and drug awareness, and to work closely with alcohol and drug treatment facilities."

McCarthy: Evolution in attitudes to drug use.

GILBERT

'. . . Who is interested in why scientists get round to conducting a particular piece of research? . . .'

Scientific intentions

By Richard Gilbert

Scientists are like the entrepreneurs of business. Businessmen and women — some of them — take an idea, develop it, turn it into a product, market the product, and use the proceeds to repeat the process with something new. The ideas are rarely wholly original. Mostly they are minor modifications of something that is already being marketed, often by the business that is fostering the new idea. There can be a lot of risk involved, unless the investment in new ideas is just a small part of the overall activity of the business.

Entrepreneurs

A good scientist is an entrepreneur of ideas. He or she will take a notion about the material world, develop it into something testable, turn the notion into a useful product by proving it with experimental or other fact, market the product, and parlay the resulting increase in stature in the scientific community into working capital for new endeavors. The scientist's ideas are rarely wholly original. Mostly they are minor modifications of something that is already being marketed. There can be a lot of risk involved: wise scientists will sustain their reputations with a steady output of marketable products.

As well as at least a superficial similarity in process, the business entrepreneur and the scientist often show a similar kind of intense absorption and dedication. Long hours, little sleep, neglected family and social life, and almost total preoccupation with the current problem characterize both types of individual. Such strong commitment makes them poor evaluators of their own products. Business entrepreneurs can test their ideas only in the marketplace. If they are wise, they begin marketing in a very small way or set up a formal test of the acceptance of their products by consumers. Scientists have a much better system. Their products are tested thoroughly for acceptance by independent evaluators before they are sprung on an unwitting marketplace.

Unpredictability

Another characteristic of both the business entrepreneur and the scientist is unpredictability. An idea for a marketable product might change radically during development. For example, hardboard, sometimes known as Masonite, was discovered accidentally while William H. Mason was attempting to make paper out of wood fibres. A malfunctioning valve caused a thick sheet of wood fibre to be steam-baked for an hour. Mason recognized the result to be a fine, strong, and almost waterproof grainless wood that was eminently marketable.

Similarly, the scientist benefits from the serendipity that comes from being in the right frame of mind when a fortuitous accident occurs. Isaac Newton's legendary apple, and Alexander Fleming's stray spore of the *Penicillium* mould, enabled solutions to the problems of gravitation and the problems of bacterial infection.

More often, unpredictability works to snare the entrepreneur or scientist rather than to allow for the sweet taste of success. Ideas for products are found to be simply unworkable or too costly to implement. Experiments do not work out: hypotheses are unproved, and the data allow no useful conclusion. Then there is the question as to whether anything can be salvaged. Can the dysfunctional product be marketed anyway, *caveat emptor*, or the idea sold to a larger corporation that can carry out necessary further development and pare production costs? Can carefully collected data be massaged into a meaningful argument that will survive the scrutiny of sceptical referees?

Some purists might argue that if an experiment is designed for one purpose, and the resulting data are found to serve another purpose, then the unfortunate experimenter should repeat the work with the new purpose in mind. An alternative view is that intention is the enemy of science, and that the best way to ensure replicable results is to have scientists who are indifferent to particular outcomes.

Experiment

This kind of question arose during analysis of the last piece of experimental work that I conducted. The idea behind the study was to apply some of the thinking of Shepard Siegel on conditional compensatory responses to the phenomena of withdrawal from smoking. (Siegel is a psychology professor at McMaster University, currently spending a year at the Addiction Research Foundation. His work was covered in **The Journal**, Dec, 1981.)

Dr Siegel has demonstrated that a stimulus that reliably precedes the administration of a drug comes to evoke a compensatory reaction to the drug, especially noticeable when the stimulus is presented but the drug does not follow.

Such conditioned compensatory responses could form the basis of the tolerance to drugs that occurs with repeated administration. The developed conditioned compensatory response counteracts the effect of the drug with the result that more of the drug is required to produce the same effect.

The compensatory responses could also form the basis of drug withdrawal syndromes and the craving that is their frequent characteristic. Searching for some support for this notion, Marilyn Pope and I looked at what happens to heavy smokers when they quit for a day. We examined various likely effects of quitting, including increased craving, and changes in body temperature, heart rate, tremor, and eating patterns. We developed measures of these effects, and looked at how they changed during the day without cigarettes. We kept a careful record of when cigarettes were smoked throughout a comparison day during which smoking was permitted, meanwhile also recording the various withdrawal measures.

Hypothesis

If conditioned compensatory responses are the basis of withdrawal responses, it follows that craving and the other withdrawal reactions should have been at their strongest when smoking would otherwise have occurred. The various environmental and internal stimuli that occasioned both smoking and the compensatory responses on the smoking day would give rise only to the compensatory responses on the day when smoking was not possible. Thus our hypothesis was that we would find a strong correlation between the pattern of smoking when smoking was permitted, and the pattern of changes in the withdrawal responses when smoking was not permitted.

Our results were as follows. Dramatic changes in the various measures were observed: even quitting for one day can have a profound effect on a heavy smoker. Craving was much more intense when cigarettes were unavailable — not a surprising finding. Heart rate was remarkably lower on the no-smoking day. The difference grew as the hours passed. By the evening of the no-smoking day, the average heart rate of our 19 subjects was 10 beats per minute below the average recorded at the same time on the smoking day (64 vs 74). Finger temperature was clearly higher on no-smoking days — as much as 4°C higher. Cheek temperature, by contrast, was hardly different. Hand tremor was not generally different between the two days, although we observed a strong, very local increase in tremor when a cigarette was smoked. Eating patterns were very different. On no-smoking days, our subjects ate less at meals but much more between meals, with the result that their overall intake of food calories was nearly 10% higher. Our subjects maintained the same balance between sweet and savoury snacks on the two days. They just ate more of both kinds (candies and peanuts) when they couldn't smoke.

Snag

We found these data to be all very exciting. The effects were strong and reliable. Our methods and data were a clear improvement over much that has been reported in the scientific literature on the effects of abstinence from smoking. An important snag was that we did not achieve clear confirmation or refutation of our original hypothesis. Statistically we found that the patterns of smoking on smoking days and craving on no-smoking days were significantly correlated, but when we graphed the results we were not impressed. For other measures there was not even a significant correlation. What were we to do?

Our decision was to report the work as simply a study of what happens to heavy smokers when they quit for one day. (The report will appear in the journal *Psychopharmacology* later this year.) We concluded that to present our data in terms of the original hypothesis would at best make for tedious reading, and at worst obscure the actual findings that we were presenting. Such obscurity would not have made for a marketable product.

Who, we asked, is interested in why scientists get round to conducting a particular piece of research? Surely the important thing is how the research is done and what the results are. Accounts of thought processes should be kept out of the scientific literature, which must remain lean and essential, and reserved for memoirs, occasional pieces, and the reports of psychologists who study the behavior of scientists. Nevertheless, we have a lingering concern that it is somehow important for the world to know that we first approached our study in one way, and eventually reported it in another.

What about conditioned compensatory responses and their role in drug abuse? I'll return to that subject next month.

NEWS

Victims encountered by chance

Thieves on drugs are 'sluggish and sloppy'

Acts of larceny by drug addicts are crimes of opportunity.

By Lynn Payer

NEW YORK, NY — Thieves who commit their crimes under the influence of opiates spend almost no time surveilling their victims and have poorer vigilance and scanning than do non-drugged larcenists, a researcher at Columbia University's College of Physicians and Surgeons has shown.

Lance L. Simpson, of the department of pharmacology, observed 100 larcenies being committed, most of them on police decoys. He said drugged criminals tended to be slow or even sluggish in approaching and leaving the victim, and victims were often encountered purely by chance.

"Acts of larceny committed by control offenders can be either crimes of design or crimes of opportunity; acts of larceny committed by offenders under the influence of an opiate are less likely to be crimes of design and more likely to be crimes of opportunity," Dr Simpson said.

He explained that, after their arrest, victims were asked to consent to an interview about their drug use, and to provide a urine sample and a blood sample. Ninety-one percent agreed to be interviewed.

Dr Simpson said they were often curious about the research and, if anything, overly willing to participate. "In about one-third of the interviews, the investigator had to encourage the subjects to be less expansive in their comments," he said. Seventy-eight percent agreed to provide a urine sample and 12% — nearly all actively involved in the self-administration of opiates — a blood sample.

Of the 100 larcenies observed, 42% were committed under the influence of a drug. Alcohol was the most commonly used drug, found in 55%, followed by opiates (26%), cocaine (7%) and marijuana (2%). Although reported use of marijuana was high, few people were under its influence at the time of their crimes.

Offenders on opiates were less likely than control offenders to be married, more likely to be unemployed, and they had more previous arrests, with every offender under the influence of an opiate having been previously arrested.

Dr Simpson suggested that opiate users, because of their lack of vigilance, are more likely to be apprehended than non-opiate users.

"This possibility has serious implications for the analysis of arrest data as a basis for estimating incidence of narcotic usage," he said.

Naltrexone treatment helps addicted health professionals

TORONTO — Health professionals addicted to opiates have been treated successfully and returned to medical practice thanks to the drug naltrexone, reports a New Jersey doctor.

Mark Gold says a recent study of 15 addicts showed 11 completed the six-month treatment. Two others discontinued naltrexone but remained opiate free and active in the drug rehabilitation program.

The benefits of naltrexone, says Dr Gold, are that it is non-addictive, has no serious side effects, no toxicity, no abuse potential, and it reduces opiate-craving. (Naltrexone is a long-acting opiate antagonist which blocks the brain's opiate receptors.)

Dr Gold, director of research at Fair Oaks Hospital in New Jersey, says opiate addiction for physicians and other health professionals is at a rate many times higher than the general population.

"While the problems of addiction have been recognized, no consensus has emerged as to the treatment modalities of choice in this population," he said in a paper presented to the American Psychiatric Association annual meeting here. "Our data reported here from 15 physicians, nurses, and other health professionals suggests that naltrexone can be useful in treatment of the health professional."

All 15 in the study were admitted to hospital and underwent a series of evaluations and tests to determine their background, and medical and family history. The first 14 days were devoted to evaluation and detoxification. This was followed by four to 10 weeks of highly-structured and multidisciplinary therapy such as lectures, psychodrama, life skills, and physical activity.

Dr Gold says this structured therapy is important because it helps the patients to keep busy and learn how to use leisure time.

During outpatient treatment, the patients received 100 mg of naltrexone on Mondays and Wednesdays and 150 mg on Fridays in pill form.

Dr Gold says most addicts report marital discord, alienation from peers, and disruption of family relationships because of the opiates.

The older doctors in the study seemed to have symptoms of depression while the younger ones, who were usually more frequent opiate users, tended to be more confused about professional goals.

"Both old and young physician addicts shared with other drug addicts the delusion that they could discontinue use of opiate drugs at any time. Job, family, and legal jeopardy helped focus the physician addict into treatment and maintain post-hospital surveillance."

Dr Gold says the one problem with naltrexone is that the patient must take it voluntarily without feeling any physical craving or need for it.

Gold: No side effects.

Cathinone may rival heroin in popularity, health risks

MONTREAL — Cathinone, a euphoric drug from East Africa, could pose public health problems as serious as heroin if it became widely available, says Robert Schuster, department of psychiatry and pharmacology, University of Chicago.

Dr Schuster says experimental tests with animals showed that Cathinone was able to compete with cocaine in a choice test.

"On the basis of our investigations, not only does it have dependence potential, but the dependence potential is effective," he said at the Canadian Psychological Association annual meeting here. "That is to say, as a positive reinforcer, it is highly efficacious."

Cathinone is the main active ingredient in the leaf of a tree grown in Kenya. For centuries, people in the East African regions have chewed the leaves for their euphoric effect.

However, unless chewed while fresh, the active ingredient deteriorates. So far this has created an insurmountable marketing problem, Dr Schuster says.

But "if Cathinone is ever available, there is no question but that it would create the same (public health) problem as heroin," he told **The Journal**.

Cathinone was unknown to the western world, he said, until 1975 when World Health Organization chemistry labs in Geneva got some frozen samples and found that the structural formula of the drug was closely related to amphetamine.

Dr Schuster's comments were made during a special session on psychopharmacology, the first time such a session has been held at the annual meeting.

Shep Siegel, a psychologist at McMaster University who also spoke at this session, said pharmacological principles alone aren't sufficient to account for drug tolerance.

"An animal with extensive experience with a drug will act like a drug-naive or drug-experienced animal depending on whether the drug is presented following cues which, in the past, have predicted the drug," he said.

A similar situation was found with the 20% of Vietnam veterans who were addicted to heroin, Dr Siegel said. A tremendous social problem was anticipated, but did not occur.

Dr Siegel said the relapse rate for the men was not the expected 80%, but only 7% because they went back to an environment different from the drug use background.

"The role of learning in tolerance, withdrawal symptoms, and relapse is a crucial one," he added.

Pharmacists upgrade image

LONDON — The National Pharmaceutical Association (NPA) here is launching an advertising campaign to persuade the public that pharmacists are more than "better-than-usually-educated shopkeepers or, worse, failed doctors."

The NPA director Tim Astill says the ads will attempt to convince people they can benefit from pharmacists' expertise and knowledge about drugs and medicine.

It's important the public realize medicines should always be bought from a qualified pharmacist who can help with problems to do with prescribed drugs, such as side effects and drug interactions, he said.

The campaign is planned for the next two or three years and will be funded by an automatic levy on membership subscriptions. If two-thirds of the members aren't in favor of the campaign when they are renewing their subscriptions, the scheme will be wound up and the money repaid, Mr Astill said.

RESEARCH UPDATE/ Austin Rand

'Moderate' alcoholics

Two out of the three largest United States studies conducted in the past decade on the relapse rate of treated alcoholics show that those drinking moderately at six months have a long-term relapse risk no greater than those who are abstainers at six months. So say the authors of this study which draws on data from the 1976 Rand Corporation report on alcoholic relapse, a 1979 study carried out in Oklahoma, and a 1979 study carried out at the Coatesville, PA Veterans Administration Hospital. More detailed data, drawn from the Coatesville study, also show that status at six months is "substantially related" to status at 12 and 24 months. Of those who were in the "abstainer" category at six months, 59% were still abstaining at 12 months, and, of that group, followed up again at 24 months, 68% were still abstinent and 21% were drinking moderately, indicating that a total of 89% were still in remission. Of those in the "moderate" drinking category at six months, 74% were still in that category at 12 months, and, of those, 85% were drinking moderately at 24 months. Similarly, of those in the "heavy" drinking category at six months, 71% were still drinking heavily at 12 months. Of those, 80% were drinking heavily at 24 months' follow-up. Overall, the authors say, "There was little evidence to suggest that individuals move progressively from abstinence through intermediate categories of drinking to heavy and uncontrolled drinking." They add that while there was some traffic back and forth across the line separating remission (drinking moderately or not at all) from relapse (drinking heavily), the movement balanced out. Of those in remission at six months, 25% and 27% were in relapse at 12 months and 24 months. On the other hand, of those in relapse at six months, 29% were in remission at 12 months and 34% were drinking moderately or not at all at 24 months.

Am J of Psychiatry, May 1982, v.139: 560-565.

Addict death rates

Opioid addicts have annual death rates between four and 14 times higher than their non-addict, same-age peers in the United States population at large, indicates a study. It followed up more than 3,000 addicts who had received treatment in community drug abuse programs between 1965 and 1969. Overall, the addicts' death rate was approximately twice as high as that of the US population as a whole (15.2 deaths per 1,000 persons per year vs 8.7 deaths/1,000/year for the general population). But, when comparisons were made within age categories, the picture changed. Among the under-21 years population, the addicts' death rate was 14 times higher (9.5/1,000/yr vs .7/1,000/yr for children ages 10 to 19). In the 21 to 30 years group, the addicts' rate was 10 times higher (13.1 vs 1.3); and in the over-30 group, addicts were four times as likely to die as their same-age peers (28.0 vs only 6.3 in the 30-64 age group of the general population). Similarly, while age makes a difference in death rate for the general population — under-21s have a death rate one-ninth of that of the over-30s — among addicts the difference shrinks, so the under-21s' death rate is one-third that of the over-30s. In the addict sample as a whole, the mode of death was "drug-related" 44% of the time, and "violent" in 28% of cases.

American Journal of Public Health, July 1982, v.72: 703-709.

FEATURES

Reluctance to act 'amazes' other countries

Insidious drug messages bombarding US youth

By Harvey McConnell

SANTA MONICA, CA — Propaganda and messages glamorizing drug use bombard young people and adults in the United States with an intensity seen nowhere else in the world.

But, Keith Schuchard, PhD, believes, "we don't have to accept the inevitability of this. We have to think about our young people, of ourselves, as being capable of a higher definition of human worth; and it is not Pollyanna, it is not utopian, and it is not puritanical."

Dr Schuchard, a founding member of the US parents' movement against drugs, and author of the widely-read book, *Parents, Peers and Pot*, says psychoactive drug use now encompasses children, adolescents, and adults in the US. She was speaking at the Cocaine Today conference held here recently. (See pages 2, 10, 11 and **The Journal**, July.)

"What we are learning, slowly, painfully, about use of these chemicals — marijuana, cocaine, quaaludes, very heavy drinking — at a very early age we are learning the hard way from the victims themselves."

She says while efforts are being made in many countries to break century-old traditions of drug use, such as hashish in Egypt or opiates in China, the US does little, to the amazement of outside observers.

"We have no organized pediatric effort to find out what is happening to boys during puberty who use marijuana heavily, or what is happening to teenagers who are using cocaine at a time when their own central nervous system and brain chemistry is changing.

"At the same time, we attack swine flu or chicken pox as though they were major threats to us."

Passivity about constant drug messages and propaganda, and the promotion of the use of drugs, "is not happening in any other society in the world as it is here in homegrown USA, where if we are going to have a new product let's build it bigger, stronger, and promote it with more gadgets and gimmickry, and mainly try to get it into the media. Well, it works."

Drugs are not only glamorized in the US, but their use is accepted as normal, she says. They are being pushed as effectively as tennis shoes, and as insidiously as sexy pubescent TV commercials sell blue jeans to pre-teen girls.

"This is why, in terms of treatment and diagnosis, we no longer look for 'predisposing personality factors' or 'underlying psychoses' of 'family differences.'

"What we have got is ordinary people — adults and kids — using drugs because they think it's ordinary. Because they are there, everybody does it."

Most people are afraid to appear 'abnormal' to their peers: teenagers who are partying, adult professionals who snort cocaine.

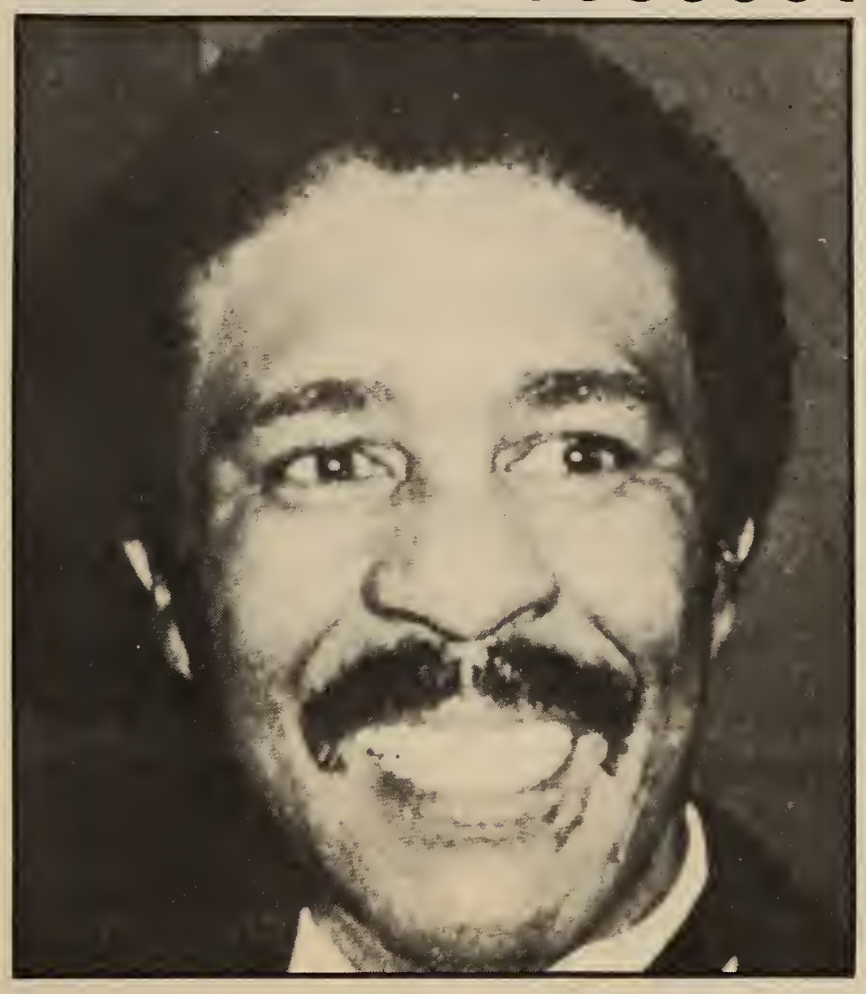
One major problem in the US, a legacy of the 1960s, is the mistaken identification of drugs as a civil rights issue, she says.

In addition, US society will not allow a drug to be exclusive: "If we have them, then they will be mass-marketed as long as we allow society to be manipulated by mass advertising techniques."

As cocaine use becomes more widespread in adult society, paraphernalia is spreading for young people: "Mickey Mouse, Donald Duck, or Barbie Doll cocaine spoons."

"Many adult drug users who see these things think them pretty gross, but they don't associate what is happening to themselves with the glamorizing of drugs in movies and records."

'Richard Pryor was presented to kids as a courageous survivor . . . not as a fool who had almost killed himself with cocaine.'



While paraphernalia may become passé, messages in what Dr Schuchard calls the respectable media "are getting worse and worse." Movies X-rated a few years ago now have ambiguous ratings, and the growth of cable television poses problems in the home.

Rock music too has many drug messages. Comic Richard Pryor, who was severely burned while indulging in cocaine freebasing, appeared recently on the cover of *Newsweek* magazine.

Dr Schuchard: "He was presented to kids as a courageous chemical survivor and not as a fool who almost killed himself with cocaine, not as a man who shot at people and beat up people."

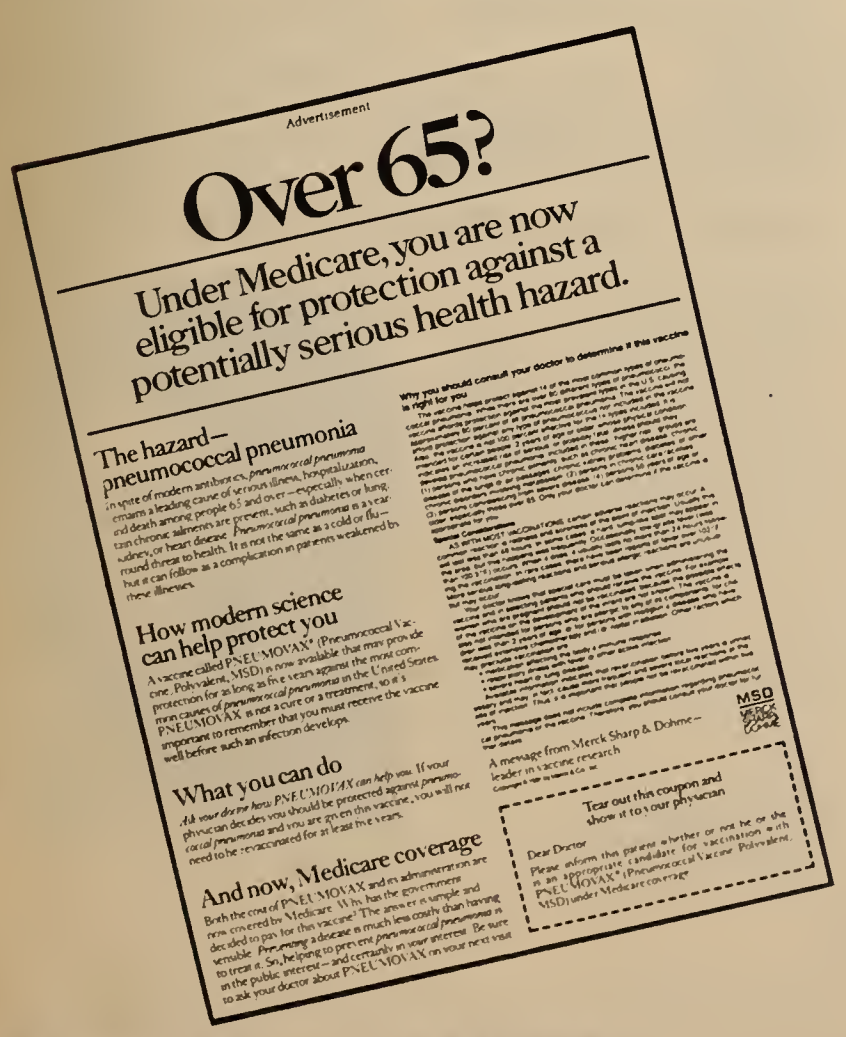
Mr Pryor, in her opinion, is presented as someone who can still go out and earn a million dollars "even after all that cocaine."

There has always been a Bohemian fringe of erratic behavior by those in the arts "but never before have we presented them as the cultural norm to our children," she adds.

Television, especially late-night weekend shows, depict such things as a Rasta man with his marijuana joint or have a skit on putting cocaine back into Coca Cola. They are seen by a large primary-school audience.

A major magazine for teenage girls feature a full-page color ad advising the young women how to get rid of red eyes before going home after a night of partying: the implication is plain that the partying included drinking and marijuana smoking, she says.

Drug companies aim for new R_x market: the doctor's patients



Advertisement

Over 65?

Under Medicare, you are now eligible for protection against a potentially serious health hazard.

The hazard— pneumococcal pneumonia

In spite of modern antibiotics, *pneumococcal pneumonia* remains a leading cause of serious illness, hospitalization, and death among people 65 and over—especially when certain chronic ailments are present, such as diabetes or lung, kidney, or heart disease. *Pneumococcal pneumonia* is a year-round threat to health. It is not the same as a cold or flu—but it can follow as a complication in patients weakened by these illnesses.

How modern science can help protect you

A vaccine called PNEUMOVAX® (Pneumococcal Vaccine, Polyvalent, MSD) is now available that may provide protection for as long as five years against the most common causes of *pneumococcal pneumonia* in the United States. PNEUMOVAX is not a cure or a treatment, so it is important to remember that you must receive the vaccine well before such an infection develops.

What you can do

Ask your doctor how PNEUMOVAX can help you. If your physician decides you should be protected against *pneumococcal pneumonia* and you are given this vaccine, you will not need to be revaccinated for at least five years.

And now, Medicare coverage

Both the cost of PNEUMOVAX and its administration are now covered by Medicare. If you have the government decided to pay for this vaccine? The answer is simple and sensible. *Preventing* a disease is much less costly than having to treat it. So, helping to prevent *pneumococcal pneumonia* is in the public interest—and certainly in your interest. Be sure to ask your doctor about PNEUMOVAX on your next visit.

Why you should consult your doctor to determine if this vaccine is right for you

Precautions

Adverse Reactions

A message from Merck Sharp & Dohme— leader in vaccine research

Tear out this coupon and show it to your physician

Dear Doctor

Please inform this patient whether or not he or she is an appropriate candidate for vaccination with PNEUMOVAX® (Pneumococcal Vaccine Polyvalent, MSD) under Medicare coverage.

MSD

Merck, Sharpe and Dohme's ad appeared in Reader's Digest.

By Kate Rodd

TORONTO — While United States drug companies are taking the controversial step of advertising prescription drugs directly to the public, Canadian health officials are maintaining their firm stand against mass promotions.

"The advertising of prescription drugs to the public is not allowed in Canada and there are no plans to change the regulations," explains Wally Maszczak, director of drug regulatory affairs for the Health Protection branch of Health and Welfare Canada.

The move to public advertisements, which has sparked concern in the health field, began last year with the tacit approval of the US Food and Drug Administration.

Unlike Canadian laws, which restrict advertising to pharmacists, doctors, and drug wholesalers US regulations allow direct-to-consumer promotions. However, the industry has voluntarily restrained itself and taken great pride in its low profile pitches to pharmacists and doctors.

But as the industry watches the results of the two recent campaigns, it seems likely other companies will follow the break with tradition to secure their share of the highly competitive pharmaceutical market.

Leading the change is Merck, Sharp and Dohme of West Point, Pa. Last autumn the company began advertising its vaccine against pneumonia, Pneumovax, in the well-read *Reader's Digest* and selected newspapers across the US.

"We chose cities which had a high population of senior citizens," Merck, Sharp and Dohme's advertising manager Roy Walker told **The Journal**. "We're still trying to reach conclusions on the campaign but it seems to have been successful; we may extend it to other products."

Currently, Boots Pharmaceuticals Ltd. of Shreveport, La is offering Americans a $1.50 rebate on each purchase of Rufen, a non-steroidal, anti-inflamatory drug used in the treatment of rheumatoidal arthritis.

To date the campaign has been well-received. Says Boots marketing spokesman John Waters: "Every day more and more coupons (for the rebate) are coming in; we thought it was one of the best ways to market drugs."

Arthur Hayes, US Commissioner of Food and Drugs, agrees with Mr Waters. In a speech last winter, he said he fully supported the promotional forays of the drug companies.

Dr Hayes believes direct appeals to patients will lead to comparison shopping, speedier licencing of new drugs, and stronger action against quackery.

Canadian drug officials do not share the Hayes optimism. They worry that public advertising, in the name of patient education, will lead to more abuses in an already danger-prone field.

Leroy Fevang is executive director of the Canadian Pharmaceutical Association in Ottawa, which represents the country's 17,000 pharmacists. He worries that advertising designed to extend markets "will stimulate usage, and we don't need that."

His concern is underlined by questions which still surround widespread use of Pneumovax. Merck, Sharp and Dohme's advertisements urged people more than 65 years old to consult their doctors about getting the vaccine which is covered by the US Medicare plan.

But the American College of Physicians cautions against its universal application in healthy elderly people. In the February *Annals of Internal Medicine*, the college advised doctors to use the vaccine only for people at high risk of developing pneumococcal pneumonia including, for example, patients whose spleens had been removed, or who suffered a variety of chronic conditions.

There is also increasing attention being given to the problems of overmedication, particularly among the elderly, and Health and Welfare is concerned that US advertising will spill over into Canada and influence Canadian patients.

In turn, patients may try and sway their doctors' prescribing habits by asking for specific medications because they have read the ads. Even though the final decisions will rest with the physician, the thought of patients self-diagnosing and demanding certain drugs is unsettling to the medical community.

Interestingly, it is a concern which is shared by the manufacturers in Canada. Despite the obvious attractions of mass advertising, Canadian drug companies have no plans to lobby the government to follow the US example.

"We're fully content with the situation," says Gordon Postlewaite, spokesman for the Canadian Pharmaceutical Manufacturers Association. "Because of the complexity of drugs we feel advertising should be limited to the professionals."

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Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

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'The Effects of Tranquillization'

Total health care costs must be considered

Thank you for reporting on our booklet *The Effects of Tranquillization: Benzodiazepine Use in Canada* (**The Journal**, June). We are concerned, however, that the wording of one portion of the article may have resulted in a misunderstanding on the part of readers. Betty Lou Lee wrote that "In exploring the etiology of tranquillizer use, the authors say that universal medicare in Canada, coupled with the public's lack of knowledge about social support services, the costs, and the stigma sometimes attached to them, results in more family, work, and personal problems being taken to physicians." Her statement gives the impression that we believe the institution of medicare has led to an increase in drug utilization.

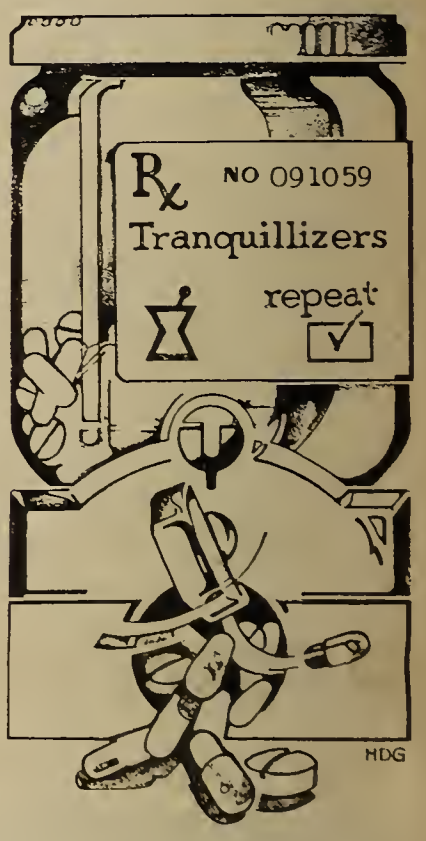
We would like to clarify our position on this. In its original form, the reference was to trends in the use of health care services, not to tranquillizer use. We did not imply that universal medical coverage in Canada was a causal factor determining rates of benzodiazepine use. Clearly, this is not the case, as the consumption of benzodiazepines in the United States, where only a proportion of the population are covered for physician visits, has been consistently higher than Canadian consumption.

In our discussion of costs, we state on p 49 of the booklet that "The costs of continued use of benzodiazepines require careful consideration. The economic cost may be incurred by the individual or through third party payment. The concern with payment must extend beyond the price of prescriptions to the total cost to the health care system. Inappropriate prescribing may well keep individuals visiting physicians, the most expensive component of the system, for considerably longer than necessary. This does not, of course, include the physical and psychosocial costs incurred through toxic reactions, adverse reactions, and overdose."

We would suggest that the use of physician services as a source of personal support may be a contributing factor to maintaining patients in the medical system, rather than channelling them to other parts of the larger health care system or other community resources where they might be dealt with more appropriately.

The booklet may be ordered free from the Health Promotion Directorate, Health and Welfare Canada, Ottawa, ON K1A 1B4. It is intended for health care workers and students, staffs of social service agencies, addiction agencies, and those in community organizations working with the elderly, the chronically ill, women, and people at risk of developing benzodiazepine dependence.

We hope our comments clarify this particular area. Thank you for your attention.



Ruth Cooperstock
Social Scientist
Social Policy Research Department
Epidemiology Section
Addiction Research Foundation
and
Jessica Hill
Ontario Regional Director
Health Promotion Directorate
Health and Welfare Canada

'Highly-relevant' reports need reference material

As an academic and a researcher, I find **The Journal** to be useful and enjoyable, particularly in highlighting political issues and treatment developments. Columnists Richard Gilbert and Wayne Howell are particularly valuable assets. Congratulations on a unique and improving publication.

One suggestion: I often find interesting, highly-relevant reports of research which are out of my own specialized discipline. It would be very useful to have the full addresses of researchers, so that I could write to them, request reprints, etc.

Stan Sadava, PhD
Professor, dept of psychology
St Catharines, ON

Sadava: A unique and improving publication.

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to: The Journal, 33 Russell Street, Toronto, Canada M5S 2S1.

Editor... Letters to the Editor... Letters to the Editor...

Young people *will* smoke so govt must soon step in

I commend Richard Gilbert and his worthy objective of stopping young people from smoking tobacco, (**The Journal**, July).

As a former nicotine junkie of 30 years, I am sympathetic when young people are suckered into addiction by the millions spent by tobacco companies in glamorizing their highly addictive and damaging drug — nicotine. Unfortunately, we will never stop young people from experimenting with tobacco. But we can go a long way to preventing nicotine addiction.

Gilbert: A worthy objective.

The federal government must soon establish control over nicotine content in tobacco. The law could then require a gradual reduction of nicotine in tobacco over a number of years until only nicotine-free tobacco could be sold.

When young people then experiment with nicotine-free tobacco, there will be no danger of a lifetime curse of nicotine addiction.

Erno Rossi
Port Colborne, ON

Howell should reconsider

Drug-induced classics survive

QUITE obviously Wayne Howell thought I was suggesting that only chemically-conscious-raised authors write memorable pieces of literature (**The Journal**, April)

I would concur with Dr Howell's statement that a writer does not need external stimulants. Many more artists without being mood-altered have produced beautiful works than the few I mentioned (**The Journal**, Feb). However, the authors I did mention wouldn't have generated their works without having been significantly into chemicals.

If Dr Howell believes for one moment that Malcolm Lowry could have or would have written *Under the Volcano* without being chemically-addicted to alcohol, he's mistaken.

Donald Newlove (**The Journal**, Oct, 1981) stated Malcolm Lowry was "A genius — when dry." That's what I take issue with and why I originally wrote in February. A writer having become alcoholic does not alter that journey by staying dry. Furthermore, a writer could not go out and try to become alcoholic in an attempt to duplicate Lowry's quality of work.

Lowry himself put it better: "And this is how I sometimes think of myself, as a great explorer who has discovered some extraordinary land from which he can never return to give his knowledge to the world: but the name of this land is hell. It is not Mexico, of course, but in the heart."

Lowry never returned from Mexico; his book did.

Hemingway never returned from the Gulf Stream: his books did.

If you're reading this Dr Howell, I would urge you never to attempt entering the inescapable dimensions. They do not make writing easier, but they do create pieces like *Under the Volcano* and *The Old Man and The Sea*.

Doug Hockley
North Vancouver
BC

Nuclear war and drugs: 'silly' political view

I suppose there are young people who drink because they have flat feet, but I doubt very much if there are enough to warrant a page one article — Parents reluctant to confront nuclear issues — on the subject (**The Journal**, June).

Your attempt to bore us with your political views by weakly attempting to bring up the nuclear issue as part of the drug problem was not only unprofessional, but silly.

I am very disappointed. Please take my name off of your subscription list.

James Riehle
Mariposa Elementary School
Oakwood, Ont

(Ed's Note: *Dr Lester Grinspoon, professor of psychiatry, Harvard University, was chairman of a symposium on nuclear war during the American Psychiatric Association annual meeting in Toronto.* **The Journal** *reported his views as well as those of others on the panel.)*

TJ gets top marks

My subscription to **The Journal** is the basis of most of my health class information. I feel my students deserve up to date material, and, I believe, **The Journal** gives precisely that.

I have been aware that I have no copy for Dec, 1981. I have searched my desks in the high school and the middle school. I am sorry to end this teaching year with a missing edition of **The Journal.** And more than ever disappointed since I find the *Kids and Teachers* section superb. I do hope the *Kids and Teachers* insert will continue in the fall.

Could I request a Dec, 1981 edition. If it is necessary to send a cheque, please notify me and I will forward one.

Louise S. Clemens
Canton, NY

MD updates Lomotil story

With reference to the article — A drug, a multinational, and the Third World — on The Back Page (**The Journal**, July) I wish to correct some statements made.

- Lomotil no longer contains atropine — at least for the past two years — since it was felt it was not necessary and also that it might cause unnecessary side effects, dryness etc.
- Atropine was put in to relax the bowel and further reduce the spasm and pain of the bowel and the diarrhea, and *not*, as I see it, to reduce the risk of addiction or abuse.

Dr J. H. Sachis
Toronto ON

Check Uncle Wayne's advice, dear nephew

(Ed's note: A reader responds to Wayne Howell's column, Creditors? Play to the crowds, dear boy — The Journal, **May.)**

Dear Nephew:

Before acting on the advice of Uncle Wayne I would give the matter careful consideration. The lady he refers to may just be on to something, and have more to sell than sizzle.

You don't agree? Dramatic revolutions of understanding are always received with coolness, mockery, and hostility. Remember Copernicus, Mesmer, Pasteur? Do you recall the professor of Padua who refused to look through Galileo's telescope? Thomas Khun explained in his landmark 1962 book, *The Structure of Scientific Revolutions*, that scientists have enormous difficulty making a paradigm shift in understanding away from a vineyard in which they have labored all their professional lives, no matter how convincing the evidence. Holistic healing and wellness, of which transpersonal therapy is one aspect, is requiring such a painful shift by your profession.

While transpersonal therapy cannot be quantified by the rational, reductionist, left hemisphere — since the time of Descartes and Newton the only verification acceptable in our scientific society — results are qualitatively real. As your uncle seems to understand, a holistic, non-linear, artistic, transpersonal mode of consciousness, opposite but complementary to the rational mode, has been found to reside in the right hemisphere (in a right-handed person).

One of your colleagues writing in a metropolitan newspaper recently advised his readers (presumably communicants at the altar of the substitute "scientific" religion founded in Vienna in the 1890s) that there are today two therapies — "supportive" and "in depth."

"Supportive" apparently means comforting the patient as he adjusts to our rational society, when the distress of our age is alienation, *not* from society, but from what Carl Jung, the father of transpersonal psychology, called the Self. Physicist Fritjof Capra points out in his remarkable new book, *The Turning Point*, that to experience reality continuously in the Cartesian mode is madness, but it is the madness of our dominant culture. While "behavioral modification" can apparently do wonders with monkeys, rats, and pigeons, you must agree it hasn't proved very fruitful with humans.

Northrop Frye has noted in *The Great Code*: "Man lives, not directly or nakedly in nature like the animals, but within a mythological universe, a body of assumptions and beliefs developed from his existential concern."

So far as "depth" therapy is concerned, it is difficult to understand how helping a patient "get in touch with" his fear, resentment, anger, denial, etc without being able to transcend it can be of any earthly benefit. Obviously, a new world view and belief system is urgently required.

All healing is self healing. I can see you nodding somewhat in agreement — medicine has reluctantly started to acknowledge the placebo effect, although it can't understand or really accept it because it is not rational and quantifiable. It appears that, if a person believes the shaman or doctor has magical powers, he will behave as if such powers do exist and heal himself. Yes, you agree — "the white coats, impressive technology, shelves of books, latin mumbo-jumbo, diploma-covered walls — our patients may just see us as, well, gods, and really, whose to blame them, eh?"

One of the great handbooks of mystical tradition does promise something from faith, hope, and charity. *Charity*? Fifty-two per cent over three years! "Fix my TV; cure my depression; or I'll sue you!" The mystique is fading fast, dear Nephew.

But you may ask if there is any empirical evidence of a transpersonal therapy capable of arresting addiction. Yes, there is indeed. AA (Alcoholics Anonymous or alteration in attitudes for some members today) born in 1936, with Dr Carl Jung synchronistically in attendance, has successfully helped far, far more people than all the Breakstone Manors in the world combined. A non-professional, non-profit, non-subsidized, non-chemical therapy that is nothing more than empathetic people acting as therapists to each other, invoking the power of group energy and a "higher power" of their own understanding, in giving up their left-brain dominated attitudes. Ego reduction — a balancing and integrating of the hemispheres, if you wish. Faith, hope, and love, dear Nephew, it's that simple. As Jung put it in his 1961 letter to Bill Wilson, one of the founders of Alcoholics Anonymous — "the helpful formula, therefore, is: *spiritus contra spiritum.*"

John V.
Don Mills, Ontario
(John V. says his thoughts are his own and he does not speak for AA.)

Scientists, parents, young people:

Do scientists at times give the general public, especially the impressionable young, misleading ideas about drug use and the possible effects of some drugs? What do scientists think of the parents' movement, which has become a major force in the United States?

These questions, although not scheduled, were asked of, and answered by a panel of distinguished scientists at the recent Cocaine Today conference in Santa Monica, California (The Journal, July). The conference was sponsored by the American Council on Marijuana and Other Psychoactive Drugs.

Although the conference dealt with current problems of cocaine use and abuse in the US, the discussion by and about scientists, their views, the information they convey, and the interpretation people may place on it, stemmed from a question put from the audience by a representative of the US parents' movement. Remarks made by Keith Schuchard, a founding member of the US parents' movement, are included here.

Comments appear virtually verbatim, with only slight modifications for clarity.

SPEAKERS:

David E. Smith, founder and medical director of the Haight-Ashbury Free Medical Clinic, San Francisco;
Ronald Siegel, psychopharmacologist, Neuropsychiatric Institute, University of California, Los Angeles (UCLA);
Gabriel Nahas, College of Physicians and Surgeons, Columbia University, New York;
Robert Petersen, former assistant director of research at the United States National Institute on Drug Abuse, and author of the yearly US Marijuana and Health reports;
Sydney Cohen, clinical professor of psychiatry, Neuropsychiatric Institute, UCLA; and
Keith Schuchard, PhD, author of *Parents, Peers and Pot*, and founding member of the US parents' movement against drugs.

Harvey McConnell reports

DAVID E. SMITH

Who, on this panel, has said one thing that could possibly be interpreted to mean that, by the wildest stretch of the imagination, we advocate drug use?

Certainly, I have never said that. In fact, when I write, and I begin as a writer, because of things that have been said recently, I say under no circumstances do I advocate any drug use. However, when you want to talk about treatment, differential diagnosis, intervention, things that are effective, like any reasonable branch of medicine, you have to make distinctions.

A person snorting cocaine once or twice a week and having absolutely no problems is not going to come into a treatment setting. He is going to come into a treatment setting when he has problems.

Does that mean I advocate that the person that is using should continue to use? No. I say abuse has to be based on sound diagnostic criteria. You treat people who have a problem.

Prevention is a quite different strategy.

For example, you talk about *High Times* advocacy. (*High Times* is a glossy, drug-oriented, consumer magazine published in the US.) I have introduced comments into *High Times* about addiction. Does that mean I advocate use? No.

It means that if you want to be effective rather than advocate a particular item or position, if you truly are concerned about the abuse of drugs by young people, then you go to where they are.

You set up a clinic in the Haight-Ashbury section of San Francisco to treat addicts. Does that mean you advocate drug use? No. It means that's where the addicts are, and so you take the treatment to them.

I do not believe such procedures are the advocacy of drug use. I believe such procedures are what people who want to be effective about drug abuse in the United States will do.

It would be ideal if everybody who has a drug problem would come up to us in this setting and say 'cure me.' But that's not what happens in the real world. If you want to help people with drug abuse problems you have to go where they are, and intervene, and establish techniques many times on their turf, whether it is down in Haight-Ashbury, whether it is trying to reach them through *High Times*, or whatever. And none of that, I believe, can be considered the advocacy of drug use.

What I have been doing recently is to say I do not advocate psychoactive drug use by anybody at any time. It's irresponsible. However, if any individual has an abuse problem, I will go to where they are and try to intervene and treat them.

The most dedicated people doing that are from AA (Alcoholics Anonymous) and NA (Narcotics Anonymous). Twelve-step work. If a 12-step Alcoholics Anonymous individual goes down into an environment where somebody is addicted to alcohol and pulls them out of that environment, is he advocating that that person use alcohol? No. That is what he is using for intervention and for 12-step work.

I do not believe these comments on intervention and treatment can be in any way interpreted as advocacy of drug use, and, if you disagree with that, I assume there are some recovering alcoholics in the audience who would give you the same message I have given you.

RONALD SIEGEL

My answer to the question which was previously raised by the parents of America, I guess, is also the answer I have to a previously unanswered question about what can we do about drug prevention.

I strongly feel that drug education is one of the best approaches and, regrettably, a lot of the people who need that education do not read, do not come to these seminars, do not read the scholarly journals, or even listen to the television with a lot of attentional awareness.

I think that a magazine like *High Times* has been directly responsible for glamorizing the drug phenomenon in America and, through their advertising and their promotion of advertisers, has been directly responsible for development of the freebase problem in America.

I feel that that audience is a very important audience to educate. I'm aware also that that audience doesn't read very well.

I have not written an article for *High Times*, I have never written an article for *High Times*, nor have I ever allowed myself to be interviewed by them, although they have reported remarks from conferences, as they probably will be reporting this conference as well.

I do draw cartoons. I am a cartoonist, I have done syndicated cartoon strips in newspapers and magazines around the country, and they (*High Times*) have published a cartoon I did on cocaine which points out the dangers of cocaine psychosis and depression, and points out also that coca is not cocaine.

It does not advocate the use of either one. It is primarily a drug educational tool. I hope it is effective. Some of those cartoons have been selected for the NIDA (United States National Institute on Drug Abuse) monograph (which Dr Siegel has written about cocaine).

I think the parents of America should be aware that the children of America are reading those cartoons — and you should get your own cartoons in there too if you have your own message — and I find that very effective.

I find it very effective in classes I teach for the Los Angeles Police Academy, the drug education films I do for the (US) Drug Enforcement Administration, and *High Times* cartoons, and I will use any vehicle I can find which will be effective in educating people about cocaine and making them aware of what the problems can be.

I would like to add just one thing . . . as the artist of the story in *High Times*, I felt I was following in the footsteps of Carlton Turner (White House advisor on drug abuse policy), who is of course (President) Reagan's adviser now. He was featured in a major cover story interview in *High Times* several months before that, and he probably feels the same way I do, that if you can educate these people in some way it would be helpful.

I should point out also that through the kind of association that Carlton has with *High Times*, that some people in NIDA have had in the past, and that I have, I was able to personally interfere with their advertising policy and get the editor at the time to pull out all their ads for freebase paraphernalia and withdraw them completely. They took a $35,000 a month advertising bath and did it on my persuasion alone. Now I take full responsibility for that.

have the messages been mixed?

GABRIEL NAHAS

This is a very touchy and controversial issue. There has been over the past 10 years a tremendous amount of effort and money spent for drug abuse prevention and treatment, mostly treatment, in the form of about — until the Reagan administration took over, I guess — half a billion dollars a year.

When one looks at the results after 10 years they are rather dismal. The drug abuse problem is far from being solved, or even stabilized. Marijuana is decreasing a little bit but cocaine and psychostimulants are increasing. The figures are staggering; the number of people who used cocaine in the past month I think is five million, versus 30 million marijuana users.

We are in the midst of an unprecedented epidemic of drug abuse in the modern world, or even in the history of the world. I am an American by choice; I came here 30 years ago when there was no drug abuse, and I can see more than anyone in this room, except maybe Dr Cohen, that this has eroded the fabric of the society.

We are speaking about a policy which has failed. The policy over the past 10 years has been one which was expressed or summarized by a parent, namely, let us teach the public, and this includes of course young people, how to use drugs in a responsible fashion.

That was the message which was in part conveyed by NIDA and NIDA publications . . . by some of the publications which are now being withdrawn . . . the message that marijuana was not a dangerous drug; that marijuana is a drug which is not much more dangerous than beer.

Over the past 20 years we have observed a very permissive attitude toward drug use with the emphasis on education and dedramatizing — removing the taboos against drug abuse and also what Dr Smith called the stigma adopted. I think this has been a very open experiment and I think that in the results which have been observed today it has failed.

My opinion, as a scientist, and as an American citizen by choice, is that this policy has failed and that it is not possible to distinguish, if one wants to contain the drug abuse problem, between drug use and drug abuse.

The scientific data indicate, as Dr Robert DuPont said today, and as documented by studies, that there is a continuum between occasional use and abuse, and it is not possible to determine the recreational user who will eventually become an abuser, and that could be within a year or two or within 10 years. The alcohol model is very clear in that respect.

The only way to solve this problem of prevention is to restore in our society the taboo against the use of addictive drugs as it existed until 1960, the taboo that protected our society, mostly women and children, against the use of these addictive drugs.

ROBERT PETERSEN

I have heard very often from Dr Nahas, and perhaps others, that we at NIDA, or its predecessor agency, we officials here at this conference, that we somehow in any sense advocated drug abuse, or moderation in drug abuse or use, as acceptable. I have heard asserted that there were such facts as would support this contention.

I know of no such evidence. The only thing I have ever heard cited was an unfortunate reference by our PR (public relations) division to a publication published by a student group, which was regarded as a not a good choice and probably wasn't.

I am not saying there have not been mistakes, but I think it has been unmistakable that throughout, as NIDA officials, and as parents, none of us took any permissive attitude that I am aware of. Nor, speaking publicly, did we take this position.

I think what has often been misconstrued, however, is the failure from some standpoints for us to assert scientifically that certain things were categorically so when the evidence was insufficient to establish whatever point was under contention.

For example, it would be nice if we could say with finality and certainty that certain consequences ensue from marijuana use without question, that brain damage, for example, unquestionably can be established, proven, demonstrated, and so on. As a reality, this isn't so. As a reality, much of the evidence is not as strong as to be utterly convincing.

It does not alter the important reality repeated by NIDA, and us as individuals, that there are very good clinical reasons for us to be concerned. As a matter of fact, Dr DuPont and I welcomed the involvement of the parents' movement. As a matter of fact, *Parents, Peers and Pot* (by Dr Keith Schuchard) would probably have never seen such a large audience, or have come to the attention of the general public quite so rapidly, if it had not been for NIDA.

Practically, one of the better examples of responsive government was our response to Dr Schuchard's letter. It arrived and I was one of those who happened to survey it, and we were very impressed with it and Dr DuPont made a point of visiting Dr Schuchard on his next trip to Atlanta.

I simply think the charges (against NIDA) don't hold up very well. Was everything we ever did wise? I doubt it. But I doubt very seriously if everything Dr Nahas has done, or anyone else has done, or our detractors, has been wise either. I could cite some very good examples of where I think crying 'wolf,' when there was no wolf, or when the wolf was not visible, had certain disadvantages in terms of credibility.

You can't subtract drug abuse from the ethos, from the total context of an age. We did not create singlehandedly a permissive age, a burgeoning youth culture in the post World War II period. A whole range of conditions, including an unparalleled prosperity, made it seem to many Americans that it wasn't just the pursuit of happiness, but human happiness itself, to which we were all entitled.

I think, to the extent that view permeated not only the view of drugs, but also the view of how many cars you should have in your garage, and every other material possession, and every other avoidance of the disease of dis-ease, perhaps ought to be taken into account, rather than looking for easy victims, glib generalizations, glib explanations, for the chaos that we find in the modern world.

SYDNEY COHEN

I think Bob's (Petersen) remarks were very good and very worthwhile hearing, and I associate myself with them.

My feeling is that the parents' groups are the best thing that have come down the pike in so far as helping prevent and deal with the drug abuse problem. Having said that, I think that they are sometimes extreme in their positions. I understand their extremism because they have been hurt, their kids have gotten into trouble with this or that drug, and they have seen kids go to pot. I understand where they come from, and I think they have to understand where they come from.

We are trying to deal with a very complicated subject in a very simple fashion, and I guess this is all right because there is really no other way to deal with it, unless we really get together for decades to unravel all the threads here.

To me, some of the things parent groups object to I can't object to. For example, and I am changing the subject a little, their opposition to the use of marijuana as a medicine. If it will help somebody, why not? It isn't giving the wrong signal, because, first of all, it isn't marijuana, it will be THC. But they still object to THC. I can't see that.

To get back to the article in *High Times* which I read but don't remember very well (Dr Siegel's cartoons), I think we have to be temperate or we run into the danger of, what shall we call it, the Anslingerism which makes us uncreditable. We have to watch that.

Otherwise, I like everything they (the parents' movement) are doing, and I would support them to the end.

KEITH SCHUCHARD

I think the clinicians here never expected cocaine to become as bad a problem as it has. I think most of us never expected marijuana to become a problem as it has become.

I think the very important thing is that we are a pluralistic group and the parents' group is not a monolithic thing.

It got started by liberal democrats who were active in the civil rights movement, which people never give us credit for. It has had the backing of Andrew Young and Jesse Jackson and all kinds of people, and looked on as outside agitators in the beginning. But once we took on segregation and worked for integration, next we began to work on drugs and what they were doing to the kids in our schools.

We were trying to do things better for kids, trying to help them both integrate, and to integrate themselves as people, that was our concern.

I think the main thing is that it is a very pluralistic group. For those people who have mad mothers, whose kids have burned their brains out, and who have lost their memory permanently, and who get angry at treatment people for not having bailed out sooner, I think you must recognize the pain is behind the anger. There have been so many kids hurt and lost. And, for families, that hits right at the instincts, and you do get mad, and you get upset.

You ought to work with that and help educate us about what is happening in many ways. . . .

I think the main thing we have to deal with is the tremendous time lag. We are not going to find out definitively what has happened to all these children, these females, these fetuses, except in an epidemiological way. For all of us who have families this scares us. We want it to happen faster.

But I think the treatment people here are speaking very honestly, and, in many ways, from my point of view, from a changed perspective than they had some years ago. And it means we may be beginning to get our act together for that consensus Dr Nahas is talking about.

Don't caricature the parents' movement as a bunch of little old ladies in tennis shoes and blue hair. There are Baptists and atheists, martini drinkers and teetotalers. The thing we have in common is that we are raising children in an awful time. We are raising them when they get messages every day that drugs are fun and games and normal. That is what we have in common as parents who come from every part of the political spectrum.

I hope we don't go into caricaturing each other. While some of us may be upset with a cartoon in *High Times* or membership in NORML (National Organization for the Reform of Marijuana Laws), when we know NORML is connected with the paraphernalia industry, I don't think that is something we can't work toward — agreement about trying to raise drug-free minors.

The questions about what many of us want to do about adult use are open to debate. But I think they have to be done with the significant recognition that the more adult usage, the more juvenile usage.

Are we willing to pay that price as a society, or discipline ourselves, on recreational use?

NEWS

Change is gathering speed in alcohol field

'Scientific, ideological revolution'

MONTREAL — The alcohol field is, in many ways, "in a state of scientific and ideological revolution," Mark Sobell of the Addiction Research Foundation told the annual meeting here of the Canadian Psychological Association.

"Today new ways of thinking replace the old. Even traditional views are being replaced," he said at a special symposium on drug dependence.

Reviewing epidemiologic and longitudinal studies, Dr Sobell discussed the present state of knowledge and conclusions believed to be warranted.

"Chronic alcoholics are but a tip of the iceberg," Dr Sobell warned. "There is a vast array of problems.

"Studies reveal that the majority of persons having identifiable alcohol problems are not physically addicted to alcohol. In fact, the highest incidence of alcohol problems among males is for individuals between 21 and 25 years of age." He noted this group has a disproportionately low representation both in treatment programs and in Alcoholics Anonymous.

Current attitudes

He said four basic questions have dominated this field of study over the years, and he summarized some current attitudes:

• Why do only some people develop alcohol problems?

"A variety of factors appear to contribute to the determination of whether or not a drinker will develop alcohol problems," he said. Although a genetic component has been identified, at least for males, this may differentiate individuals only in terms of consequences. He suggested the genetic contribution may take the form of "differential vulnerability to alcohol-related organ damage, rather than affecting drinking behavior per se."

Many sociocultural and personality factors are a forewarning, but "no single factor has been found to be prepotent or even to account for a substantial amount of the variance in predicting drinking problems."

• Why do individuals who have previously experienced adverse consequences of drinking choose to drink again?

"Research has heavily implicated learning factors as influencing decisions to drink," he said. However, the learning factors investigated reflect learned means of coping with negative affect or social pressures. "The thesis that drinking may be precipitated by the occurrence of a conditioned withdrawal reaction, triggered by cues associated in the past with an aversive withdrawal state, may prove to have some explanatory value." But this would seem limited to people physically addicted or those who have developed tolerance to alcohol in the past. "The epidemiologic literature demonstrates that such individuals probably constitute only a minority of those persons who experience serious alcohol problems."

Avoidance

• Why do people find it difficult to stop drinking?

Avoidance of the onset of withdrawal symptoms continues to be an explanation of continued drinking after physical addiction has occurred. "Research clearly indicates that addiction is not initiated until considerable continuous heavy drinking has occurred, usually over a few days," the ARF scientist pointed out. Research has been scarce on other factors, but Dr Sobell suggested future research will focus on learning and cognitive factors.

Non-problem drinking

• What is the natural history of the disorder? In particular, is it progressive with a well-specified train of symptoms? Is it irreversible?

"The predominant pattern in the natural course of alcohol problems appears to be one of individuals having periods of drinking problems of varying severity, interpolated with periods of no identifiable drinking problems. These problem-free periods may be characterized by abstinence or by non-problem drinking." The fact is that only a small number of individuals demonstrate progressivity, he said.

And is alcoholism reversible? Dr Sobell said evidence from a great many sources suggests an affirmative answer. He warned, however, that non-problem drinking outcomes are more likely to be achieved by those who have had less serious alcohol problems, especially a lack of physical dependence. But even previously-addicted alcoholics have been found to be able to achieve long-term, non-problem outcomes, he said.

Dr Sobell said "the winds of change have been gathering speed," and yesterday's heresy is today accepted by at least some traditionalists.

"Change will be slow in impacting on rank-and-file workers in the alcohol field, but changes are beginning to occur," he said.

Cdn psychiatrist observes drinking trends

Westerners, Protestants at greater risk?

By Pat Ohlendorf

TORONTO — Alcohol problems increase as one moves west across Canada and also appear to be higher among Protestant groups, Juan Carlos Negrete, psychiatrist at Montreal General Hospital, told an international gathering of scientists here.

Among the 10 provinces, and excluding the Yukon and Northwest Territories, British Columbia ranks highest in per capita alcohol consumption, cases of cirrhosis of the liver, rates of violent crime, arrests for disorderly conduct and drunk driving, and numbers of women drinkers, Dr Negrete told the annual meeting of the Committee on Problems of Drug Dependence.

Rates of police reports of drunk driving arrests and violent crimes increase almost in step fashion from the Maritimes to BC with the exception of Quebec. It has fewest drunk driving offences and second lowest rate (after Prince Edward Island) of violent crimes.

One possible explanation for the differences, Dr Negrete told **The Journal**, is religious differences. "I noticed there is a correlation (of alcohol-related problems) with the distribution of Protestant and non-Protestant affiliation in the population."

Alcohol-related problems, he said, seem to be higher among Protestant populations. More Protestants than Catholics are abstainers, which indicates both disapproval of alcohol and unfamiliarity with moderate drinking patterns.

"It's partly a matter of the 'self-fulfilling prophecy'," Dr Negrete said. "If you do something you have been taught is wrong and will cause damage when you engage in that behavior, you tend to fulfill the prophecy." Hence Protestant drinkers tend to be more disruptive when intoxicated than Catholics. While consumption and alcohol-related problems are highest in British Columbia, Dr Negrete said, so is the proportion of abstainers in the population.

Another possible reason for the higher number of arrests among Protestant drinkers, suggested Dr Negrete, is that young drinkers are not as often exposed to models of "good drinking behavior as Catholics are." Hence they tend not to be able to control their drinking as well as those from families where alcohol is consumed regularly, and are more often arrested for disorderly conduct when drunk.

The correlation between drinking problems and religious affiliation is not confirmed in Canada. Dr Negrete said a US study questioned 16,000 high school students about their first drinking experience, and compared their responses with their religious affiliations. Young people from "abstainer groups" were found to face more difficulties than those from non-abstainer groups. They were arrested more often for drunkenness, and tended to drink away from home, stay away from home overnight, and get into fights more frequently.

Negrete: Self-fulfilling prophecy.

Although Dr Negrete admitted some differences between Catholic and Protestant drinking behavior might relate to differences in police arrests and reporting practices, a study he made in 1970 of Quebec alcoholics seems to uphold the religious hypothesis.

"In comparing the histories of Quebec alcoholics, I noticed that Anglo-Protestant alcoholics tended to be arrested on public drunkenness charges more frequently than French-Catholic alcoholics," he said. "And the arrests were made by the same police."

Dr Negrete's observations on more drinking problems in the west and among Protestants hold only for the provinces.

The Yukon and Northwest Territories have the highest rate of alcohol consumption and alcohol-related problems in Canada, and religious affiliation doesn't have much to do with it.

Although genetic differences in alcohol metabolism might have some bearing on the higher rates of drinking problems in the territories (which are about 73% native), Dr Negrete believes a better explanation is lack of models for moderate drinking in the North.

"Natives in Canada did not have any aquaintance with alcohol before the Europeans arrived," Dr Negrete told **The Journal**, except for the Hurons, the only tribe that traditionally made intoxicating beverages. The Inuit, he said, were introduced to alcohol only in the 1920s and 30s.

"Native people learned to use alcohol for the express purpose of getting intoxicated," Dr Negrete said. "They learned the use of alcohol from 'frontier men' who were themselves problem drinkers."

Correction

In an article, Pink lungs cure may be harmful . . . (**The Journal**, July) Lynn Kozlowski of the Addiction Research Foundation was quoted as saying that swallowing cigarette tobacco would be worse than swallowing chewing tobacco, for example, because it's not as easily broken down in the body. Dr Kozlowski writes: "I know of no key difference between swallowed cigarette and swallowed chewing tobacco . . . What I told the reporter was the Nicorette® (nicotine chewing gum) was safer than tobacco because it needed to be chewed to release nicotine and therefore, swallowing the gum was not as hazardous as swallowing tobacco."

NEWS

Athletes ignore anti-drug evidence, health risks

By Mark Kearney

TORONTO — Athletes continue to pop pills at increasing rates to improve performance and handle the pressures of big-time sports.

What they don't seem to be swallowing is the evidence that the drugs may be ineffective and a health risk.

Thomas Murray, PhD, an associate for social and behavioral science at the Hastings Centre, Hastings-on-Hudson, NY, says many experts believe drugs such as anabolic steroids are not as essential to improving performance as athletes seem to think.

However, drug use continues, and in many cases athletes seem to be using them at younger ages than before, Dr Murray told delegates at the American Psychiatric Association annual meeting here. In one recent survey of powerlifters, for example, 100% of them admitted to using steroids to build up their muscle strength.

So far, only the athletes who have been caught using illegal drugs have been punished. What is needed, Dr Murray says, are penalties for coaches, trainers, or anyone else dispensing drugs to athletes.

"Intense competition at high levels of sport push them (the athletes) to gain an advantage over their competitors. It's difficult to refuse the drugs when you know your competitors are using them."

Many athletes have reported sudden gains in strength when they start taking drugs. However, Dr Murray says experts have gathered evidence that seems to refute this belief.

In addition, there are other side effects that can result from taking steroids. Studies show the drugs can affect fertility, cause acne, or, possibly, build up cholesterol levels. In women, the drugs lead to lower voice, possible hair loss, and a masculine build.

Many tests have been developed by sport officials to detect use of the drugs, especially at Olympic games, but there is no guarantee athletes won't be able to find loopholes, Dr Murray adds.

In other sports such as football and baseball, painkillers and amphetamines seem to be the most-common drugs used to enhance performance. Dr Murray recounted one story of an injured football player.

Before giving a painkiller, the trainer asked: "What else did you take today?"

Therapists must be on alert for relapse clues

TORONTO — An alcoholic who has been receiving treatment for a few months tells his therapist that he's learned his lesson. In fact, the therapy has worked so well that he believes he can now handle having one drink.

A success story, right?

Wrong, says Margaret Bean of the department of psychiatry at the Harvard Medical School, Boston. Such a scenario is an indication the alcoholic is having a relapse and may be moving away from becoming a sober individual, she told a session at the American Psychiatric Association annual meeting here.

Bean: The sober psychology.

Dr Bean says it's essential that therapists recognize such behavior as a relapse, and intervene in time to restore "the sober psychology."

Other signs of relapse may be an expressed desire to have a drink now, without considering the long-term consequences, or an admittance by the alcoholic that he's tried his best but the therapies just aren't working. Such behavior can be exhibited even after lengthy treatment, she says.

Dr Bean says alcoholics who are part of the sober psychology will not behave or say such things. They admit they have a problem, believe the treatment is working, and will understand that while a drink may give them short-term relief it will hurt them in the long run.

It's necessary for therapists to recognize these differences to ensure more success in changing "an actively-drinking alcoholic" into a "sober, stable one." However, these signs are not so clear cut that they can always be recognized easily.

"I think alcoholism is complicated even when it's simple," Dr Bean told the meeting.

She stressed that the first step to any recovery is to put (the alcoholic) in a safe environment such as a hospital or halfway house to ensure basic needs are met. If an alcoholic is getting treatment but is still living in the street where there are more dangers and temptations it will be difficult for him or her to progress.

"If they are hurt (because they continue to drink) they can't learn to stay sober."

The therapists should also keep the word HALT in mind. That is, they should make certain the alcoholic doesn't become Hungry, Angry, Lonely, or Tired when being treated. Otherwise it may seem like withdrawal symptoms to the alcoholic who then becomes a higher risk to start drinking again, Dr Bean said.

Only when these basic needs are met and sustained should a therapist begin to try to teach the alcoholic new behaviors; all these steps are linked tasks the alcoholic should follow toward recovery.

Dr Robert Niven of the Mayo Clinic in Minnesota said at the same session that dealing honestly and "up-front" with alcoholics is important especially with adolescent drinkers who may see dishonest actions as manipulative, and rebel against any attempt at therapy.

'Moral order' poor basis for drug abuse laws

TORONTO — Policy makers should concentrate on health and safety hazards, and not on preserving the "moral order" of society, when determining drug abuse laws, says a law lecturer at the Harvard Medical School, Boston.

"The notion of preserving a moral order is usually a poor basis for policy, if only because it tends to be applied mainly in areas where true cause and effect are hard to determine," says James Bakalar.

However, in the area of health problems "drug abuse is clearly a cause, and not a symptom."

Yet, the idea of preserving the moral order has figured prominently in determining the laws, he says in a paper which was presented at the annual meeting here of the American Psychiatric Association. It was co-written with Harvard colleague Dr Lester Grinspoon.

Mr Bakalar says the moral preservation argument can be inconsistent because there seems to be no clear-cut method for deciding which drugs should be banned, and which should not. He cites alcohol as an example of a drug that can be as dangerous as others but has not fallen prey to the law.

And "if any drug could destroy the fabric of society, alcohol would have done it by now," he says.

Mr Bakalar says the most-common argument used to justify the inconsistency is that prohibition for alcohol doesn't work as it does for other drugs. However, he argues that prohibition in the early 1920s seemed to reduce the consumption of alcohol and the harm done by drinking.

"Repeal came not because prohibition was totally ineffective, but because we decided . . . that we valued the pleasure of convenient legal alcohol more than we feared an increase in drunkenness and alcoholism.

"We concede that alcohol is a very dangerous substance and creates a vast health problem, but can also be a harmless indulgence. But apparently the strain of tolerating the ambiguity is great, because, at least officially, we are unable to do the same for any other drug, even when there is little evidence that the drug could ever be as dangerous as alcohol."

However, Mr Bakalar says, although we have different legal and social sanctions for different drugs "perhaps they represent some collective historical wisdom."

Projections

The Projections column will resume in the autumn.

DEPARTMENT

New Books by RON HALL

Drug Use Among Non-Student Youth

. . . by R.G. Smart, A. Arif, P.H. Hughes, Maria Elena, Medina Mora, V. Navaratnam, V.K. Varma, and K.A. Wadud

Although most European and North American youth attend school until they are 16 or 17 years of age, the situation is quite different in many developing countries. Most studies of drug use and youth have dealt with students despite this large population of non-students and the fact that young people not at school have special social and personal problems that predispose them to drug use. This report describes the background to the study, the development and testing of a questionnaire for assessing the factors associated with non-student drug use, and the findings at the various centres in the five countries. It then reviews the methodological issues arising out of the study and examines the trends in the data. One of the principal findings was that more non-students than students use drugs and that they use them more frequently. The report suggests that action might be taken to improve the quality of life for non-students and thus reduce their desire for drug use. The questionnaire is reproduced as an appendix.

(World Health Organization, available from: Canadian Public Health Association, 1335 Carling Avenue, Suite 210, Ottawa, Ontario K1Z 8N8, 1981. 58p. ISBN 92-4-170060-2)

Just So It's Healthy

. . . by Lucy Barry Robe

This revised edition includes an alcohol section which is three times the length of the one included in the 1978 edition, and offers the latest information about symptoms of fetal alcohol syndrome, research on the effects of moderate drinking and binge drinking on the unborn child, and newborn withdrawal from alcohol. Chapters have been added on alcohol-related birth defects, counselling mothers and damaged children, the father's role, hyperactive children, and educational resources. New information presented in the drug section includes: effects of marijuana, caffeine, saccharin, and amphetamines. Information about prescription, over-the-counter, and street drugs has been updated.

(CompCare Publications, 2415 Annapolis Lane, Minneapolis, MN 55441, 1982. 165p. $6.95 ISBN 0-89638-062-9)

This publication is indexed in

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BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

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½ Page (560 lines) — $500
¼ Page (280 lines) — $250
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Circulation: 15,094

(Ontario, 11,580, other provinces, 815, USA, 1,979, foreign, 720) Bulk, 3,700, Media, 1,273

Single Subscription Rates
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ISSN 0044-6203 Printed in Canada

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Workshop on Evaluation Research in the Field of Addictions — Sept 8-9, Regina, Saskatchewan. Information: Brian Rush, Addiction Research Foundation, Research Centre for Regional Programs, University of Western Ontario, London, ON N6A 3K7.

One Another As Resources - 1982 Pacific Western Conference on Alcohol Problems — Sept 9-11, Vancouver, British Columbia. Information: Patrick Crawshaw, Convenor, Vancouver Community College, Continuing Education, Langara Campus, 100 West 49th Avenue, Vancouver, BC V5Y 2Z6.

Canadian Medical Association Annual Meeting — Sept 20-24, Saskatoon, Saskatchewan. Information: CMA Office, University of Saskatchewan, 408 Ellis Hall, Saskatoon, SK S7N 0W0.

Early Recognition and Management of Health Problems in the Workplace — Sept 27, Oct 28, Nov 25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Road, Toronto, ON M4G 3Z1.

Detox Training Programs (Non-Medical) — Sept 27-Oct 1, Oct 25-29, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Canadian Psychiatric Association 32nd Annual Meeting — Sept 29-Oct 1, Montreal, Quebec. Information: Lea Metivier, Chief Administrative Officer, Canadian Psychiatric Association, Suite 103, 225 Lisgar, Ottawa, Ontario K2P 0C6.

Librarians and Information Specialists in Addictions — Oct 5-8, Ottawa, Ontario. Information: Betty Garland, Librarian, Health Services and Promotion Branch, Room 500, Jeanne Mance Building, Ottawa, ON KIA 1B4.

The National Conference of the Canadian Mental Health Association — Oct 6-9, Victoria, BC. Information: J. Terry Gordon, Assistant Executive Director, Canadian Mental Health Association (BC Division), 692 East 26th Avenue, Vancouver, BC V5V 2H7.

American College of Chest Physicians — Oct 10-15, Toronto, Ontario. Information: A. Soffer, MD, FCCP, 911 Busse Highway, Park Ridge, Illinois 60068.

International Association For Pupil Personnel Workers 71st Annual Convention — Oct 17-21, Toronto, Ontario. Information: Joseph Yurkiw, Chairman, Publicity & Promotion Committee, IAPPW, c/o The Hamilton Board of Education, PO Box 558, Hamilton, ON L8N 3L1.

American Society of Criminology — Nov 4-6, Toronto, Ontario. Information: Harvey C. Horowitz and Associates, 10369 Currycomb Court, Columbia, Maryland 21044.

Medical Device Technology in the '80s — Dec 6-8, Toronto, Ontario. Information: Canadian Association of Manufacturers of Medical Devices (CAMMD), 480 Garyray Drive, Toronto, ON M9L 1P8.

The Management of Employee Assistance Programs — Feb 23-25, 1983, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Road, Toronto, ON M4G 3Z1.

25th Annual Scientific Assembly of the College of Family Physicians of Canada — Apr 24-27, 1983, Toronto, Ontario. Information: George Ackehurst, Director of Communications, The College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, ON M2K 2R9.

Medic Canada '83 . . . Toward the Year 2000 — May 29-31, 1983, Edmonton, Alberta. Information: Toby Fay Sykes, Medic Canada 283, 480 Garyray Drive, Toronto, ON M9L 1P8.

Fifth World Conference on Smoking and Health — July 10-15, 1983, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, Ontario, K1A 0C1.

United States

4th Annual Meeting of NCCAC — Aug 15, Long Beach, California. Information: Dr Valle, American International Health Services, 101 North Common St, Lynn Massachusetts 01902.

The National Association of Alcoholism Counsellors Annual Meeting — Aug 15-18, Long Beach California. Information: NAAC, 951 S George Mason Drive, Arlington, Virginia 22204.

American Society for Pharmacology and Experimental Therapeutics — Aug 15-19, Hyatt, Louisville. Information: K. A. Croker, ASPET, 9650 Rockville Pike, Bethesda, Maryland 20814.

Chemical Dependency and Family Recovery Workshop — Aug 15-20, Minneapolis, Minnesota. Information: Mary Simonson, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN 55441.

Kid's Stuff: A Conference on The Prevention of Alcohol/Drug Abuse Among Youth — Aug 23-25, Austin, Texas. Information: Peggy Frias-Lynch, Prevention Coordinator, Texas Commission on Alcoholism, 8th floor, Sam Houston Bldg, Austin, TX 78701.

Treatment Directors Seminar — Aug 25-27, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Memorial Hwy, Minneapolis, MN 55441.

The Alcohol and Drug Problems Association of North America 33rd Annual Meeting — Aug 29-Sept 1, Washington, DC. Information: Eric Scharf, ADPA conference coordinator, 1101 15th St NW, Suite 204, Washington, DC 20005.

6th Annual Summer Institute of Drug Dependence — Aug 29-Sept 3, Colorado Springs, Colorado. Information: The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Family Program for Professionals — Aug 30-Sept 2, Center City, Minnesota. Information: Continuing Education, Box 11, Center City, MN 55012.

An Integrated Management System for Administrators in Alcoholism — Sept 9-10, Chicago, Illinois, Oct 13-14, Phoenix, Arizona. Information: Kim Hilberg, Program Coordinator, NAATP, 1300 Bristol Street North, Newport Beach, California 92660.

International Conference on Human Functioning — Sept 9-12, Wichita, Kansas. Information: B. Richards, 434 N Oliver St, Wichita, KA 67208.

Evaluating Alcohol and Drug Programs: Current Methods and Findings — Sept 13-17, Brooklyn Park, Minnesota. Information: Leslie Nyberg, Evaluation and Research Department, Box 11, Center City, MN 55012.

Training School on Alcohol and Drug Abuse — Sept 13-30, Minneapolis, Minnesota. Information: Betty Reynolds, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441.

2nd Annual Workshop on Marketing Mental Health and EAP Services — Sept 15-18, Snowmass -Aspen, Colorado. Information: Sara Bilik, Colorado West Regional MH Center, PO Box 1580, Glenwood Springs, CO 81602.

Alcoholism Treatment: Cooperation or Competition — Sept 20-22, La Jolla, California. Information: Naomi Feldman, Conference Coordinator, 3770 Tansy, San Diego, CA 92121.

Intervention Skill Building Workshop — Sept 20-24, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441.

5th National Impaired Physician's Conference — Sept 22-25, Portland, Oregon. Information: AMA Department of Mental Health, 535 N, Dearborn, Chicago, Illinois 60610.

The 5th Annual Current Concerns in Adolescent Medicine — Sept 23-24, New York, NY. Information: Ann Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

American Neurological Association 107th Annual Meeting — Sept 30-Oct 2, Washington, DC. Information: John Conomy, MD, Chairman, Press and Public Relations, American Neurological Association, The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio 44106.

The Benzodiazepines Today: Two Decades of Research and Clinical Experience — Oct 8-11, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton Street, San Francisco, CA 94117.

6th Annual Drug and Alcohol Abuse Conference — Oct 12-14, Lancaster, Pennsylvania. Information: Carol A. Williams, Chief, Division of Intervention Services, Office of Drug and Alcohol Programs, 2010 N Front Street, Building #3, Harrisburg, PA 17120.

Conference on Alcoholism Treatment Evaluation: Issues and Applications — Oct 14-15, Fort Worth, Texas. Information: Wendy Lipton, Center for Organizational Research and Evaluation Studies, Texas Christian University, PO Box 32874, Fort Worth, TX 76129.

Directions in Alcohol Abuse Treatment Research — Oct 20-23, Newport, Rhode Island. Information: Barbara S. McCrady, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906.

American Academy of Child Psychiatry — Oct 20-24, Washington, DC. Information: V. Bausch, 1424 16th St NW, Suite 201A, Washington, DC 20036.

American Academy of Psychiatry and the Law — Oct 21-24, New York, New York. Information: B. Parsons, 1211 Cathedral St, Baltimore, Maryland 21201.

National Black Alcoholism Council Inc, 4th Annual National Conference — Oct 21-24, San Diego, California. Information: Don Owens, NBAC National Conference Planning Committee, 4208 National Avenue, San Diego, CA 92113.

Healing In Our Time — A Symposium on the Dynamics of the Healing Process — Oct 21-25, Washington, DC. Information: Symposium, Route 2, Box 166, Leicester, North Carolina 28748.

Annual Postgraduate Course in Clinical Pharmacology, Drug Development and Regulation: 1982 — Oct 25-29, Rochester, New York. Information: William M. Wardell, The University of Rochester Medical Center, Department of Pharmacology and Toxicology, 601 Elmwood Avenue, Rochester, NY 14642.

3rd Annual Seminar, Alcoholism in the Black Community — Oct 30, Newark, New Jersey. Information: ABC, c/o RAFT, East Orange General Hospital, 300 Central Avenue, East Orange, NJ 07019.

American Association for the Study of Liver — Oct 31-Nov 3, Chicago, Illinois. Information: M. Sorrell, MD, Department of Internal Med, University of Nebraska Med Center, 42nd and Dewey Ave, Omaha, Nebraska 68105.

Association for the Advancement of Psychotherapy — Oct 31, New York, New York. Information: S. Leese, MD, 114 E 78th St, New York, NY 10021.

11th Annual Meeting of the Association of Labor Management Administrators and Consultants on Alcoholism (ALMACA) — Nov 2-5, Philadelphia, Pennsylvania. Information: ALMACA, 1800 N Kent St, Suite 907, Arlington, Virginia 22209.

Alcoholism: Culture and Treatment: Comparative Perspectives from Europe and America — Nov 4-6, Farmington, Connecticut. Information: Margie Meadows, Administrative Assistant, Department of Psychiatry, University of Connecticut Health Center, Farmington, CT 06032.

Women In Crisis Inc, Fourth Annual Conference — Nov 10-13, New York, New York. Information: Women In Crisis, Inc, 37 Union Square West, New York, NY 10001.

An International Perspective on Substance Abuse: The Problem, Its Treatment, and Medical Education — Nov 15-19, Oakland, California. Information: Dr Charles Buchwald, Conference Coordinator, Downstate Medical Center, 450 Clarkson Ave — Box 129, Brooklyn, New York 11203.

7th Southeastern Conference on Alcohol and Drug Abuse "SECAD" — Dec 1-5, Atlanta, Georgia. Information: Barbara Turner, Conference Coordinator, "SECAD/7", Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree-Dunwoody Road — Suite 170, Atlanta, GA 30342.

American Medical Society on Alcoholism — Apr 14-20, 1983, Houston, Texas. Information: J. Chen See, MD, AMSA 733 3rd Ave, New York, NY 10017.

Scholarly Communication Around The World — The 27th Annual Conference of the Council of Biology Editors, The 3rd International Conference of Scientific Editors and The 5th Annual Meeting of the Society for Scholarly Publishing — May 15-20, 1983, Philadelphia, Pennsylvania. Information: 1983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Service, 2100 Arch Street, Philadelphia, PA 19103.

Abroad

11th International Conference on Health Education — Aug 15-20, Hobart, Tasmania, Australia. Information: Joy Faldt, Australian Society of Health Educators, PO Box 818, Fortitude Valley, Queensland, Australia 4006.

Working With Problem Drinkers — Aug 23-27, York, England. Information: Jane Stott, Course Coordinator, Alcohol Education Centre, 99 Denmark Hill, The Maudsley Hospital, London SE5 8AZ.

Fourth World Congress for the Prevention of Alcohol Problems, Alcoholism and Drug Dependency — Aug 29-Sept 2, Nairobi, Kenya. Information: ICPA — International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St. NW, Washington, DC 20012.

33rd International Congress on Alcoholism and Drug Dependence — Oct 9-15, Tangier, Morocco. Information: Archer Tongue, International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

Influence of Environment on Man — Nov 17-20, Vienna, Austria. Information: Secretariat Brussels, rue E. Bouillot 61 Box 11, B-1060 Brussels, Belgium.

International Conference on KHAT — The Health and Socio-Economic Aspects of KHAT Use — Jan 17-21, 1983, Antananarivo, Madagascar. Information: Archer Tongue, Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

NSAD 10th Biennial Summer School on Alcohol, Drugs and Chemical Dependency — Jan 26-28, 1983, Wellington, New Zealand. Information: Bursar, Barbara Mills, NSAD, PO Box 1642, Wellington, New Zealand.

7th World Congress of Psychiatry — July 11-16, 1983, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, 1983, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

2nd International Congress on Drugs and Alcohol — Dec 18-22, 1983, Tel Aviv, Israel. Information: Judge Amnon Carmi, Chairman, Organizing Committee, 2nd International Congress on Drugs and Acohol, PO Box 394, Tel Aviv 61003, Israel.

The search for new 'highs' goes on

By Harvey McConnell

SANTA MONICA, CA — Qat, a plant indigenous to South Yemen and a stimulant which has an effect very much like cocaine's when it's chewed, may soon become a cocaine substitute among many drug users in the United States.

California psychopharmacologist Ronald Siegel says: "There are no reports of people in the US growing it, but we know some people are using Qat, although we don't have the foggiest idea where they are getting it."

60,000 plant species

He adds: "We do grow it at the botanical gardens at the UCLA, (University of California, Los Angeles), and I imagine it can be grown elsewhere. I would have guessed that with the increasing restrictions on cocaine we would see users searching for alternatives, and finding in the not-to-distant future something like that.

"After all, we have something like 60,000 plant species on this planet and only about 60 are really exploited for psychoactive drugs."

Dr Siegel sees no end to the search by people for drugs: "Demand will always remain high for intoxication from chemical and non-chemical means. Our species is motivated in this direction," to alter consciousness and to titrate use to alter moods.

Currently, Dr Siegels says, continual monitoring of the drug underground by him and his colleagues at the UCLA shows a trend toward a revival of LSD use. The first signs were spotted in the late 1970s, and assays of street drugs show an increased potency in LSD for sale.

"Yet, we are seeing a paucity of adverse reactions, as if to suggest that users are learning how to control their drug experiences better and that they are much more sophisticated," Dr Siegel continues.

He finds this use of LSD sad "because the psychedelics were part of a very important cultural movement in this country in the 60s, and they came with a philosophical message and with a cultural message, and that message is lacking now. People are taking these drugs purely for entertainment purposes, and I think that is a waste of a very powerful psychoactive chemical that may have good therapeutic applications that may be heretofore unknown in psychiatry."

Many of the LSD users in California like to go to amusement parks and go on rides while they are high, Dr Siegel adds.

The psychedelic which seems to be most popular, and most prevalent at present, is psilocybin, a mushroom whose spores may be sold legally in the US because they do not have any detectable psychoactive alkaloids. They can easily be grown in a jar tucked away in a dark corner.

Dr Siegel says that in low doses it can be managed by most users. Large doses are unlikely because the mushroom produces transient nausea and this probably tempers intake.

Experiments at the UCLA among healthy volunteers given 11 different hallucinogenic drugs found the majority preferred psilocybin, and the mushroom produced the least number of physiological and psychological reactions.

Psychedelic age

"If these trends continue, and I think they will, then we can look forward to the 90s as being another psychedelic age with psilocybin and drugs like that being very popular," Dr Siegel predicts.

He sees a search for more stimulants to replace amphetamines, "which I think, correctly, are becoming more restricted," and cocaine. There is a rise in the use of a lot of look-alike amphetamines and over-the-counter stimulants.

Recent studies have shown that procaine and lidocaine have strong stimulant effects in the brain, and procaine, especially, has very strong reinforcing effects. "It is possible these two local anesthetics may replace cocaine if cocaine tracking becomes more controlled," Dr Siegel believes.

Another trend, he suggests, is exploration of exotic synthetic chemicals. There has been an interest shown by users in MDA, MMDA, and other analogues of amphetamines.

Dr Siegel: "The alchemists we have, at least here in California, are very innovative, and they are constantly turning up new compounds, so many that we can't even monitor them.

"They are way ahead of us, and the drugs that may be on the horizon are probably around now, but we have not gotten around to analyzing them yet."

Dr Siegel says it can be argued that the use of chemical substances by the human species "has always been with us." Even many animals eat plants which make them intoxicated.

A number of research stations around the world, in collaboration with the UCLA, study and photograph animals which eat psychoactive plants for non-nutritive reasons and get high.

He points out that coffee was first used by man when goat herders in Abyssinia noted the animals got friskier after nibbling the ripe, red fruit; and Incas started to use coca leaves after watching their llamas chew the leaves of the coca bush.

Recently, a couple of drugs have been discovered in Mexico through watching animals forage among particular plants.

"Man has always explored drugs and it is not likely that we can remove the curiosity to explore," he adds.

Dr Siegel believes that in that context "one of the things we must start to think about is the possibility of clearing up what we do have. The notion of a totally-safe entertainment drug is one that has been around a long time in the science fiction world."

Aldous Huxley in *Brave New World* (1930) wrote about a drug which would be used to sedate the people by a totalitarian state, but in *Island* (1962) he wrote about a drug he called moksha, a truth and beauty pill which would be taken to reveal reality.

Dr Siegel: "It should be noted that in the period between the two books Huxley had eight to 12 psychedelic experiences and he changed his mind about drugs."

Dr Siegel says an ideal recreational drug would have to come from something safer than nicotine, alcohol, caffeine, marijuana, or cocaine and "there may not be such a thing as an ideal, safe drug."

Safe drugs

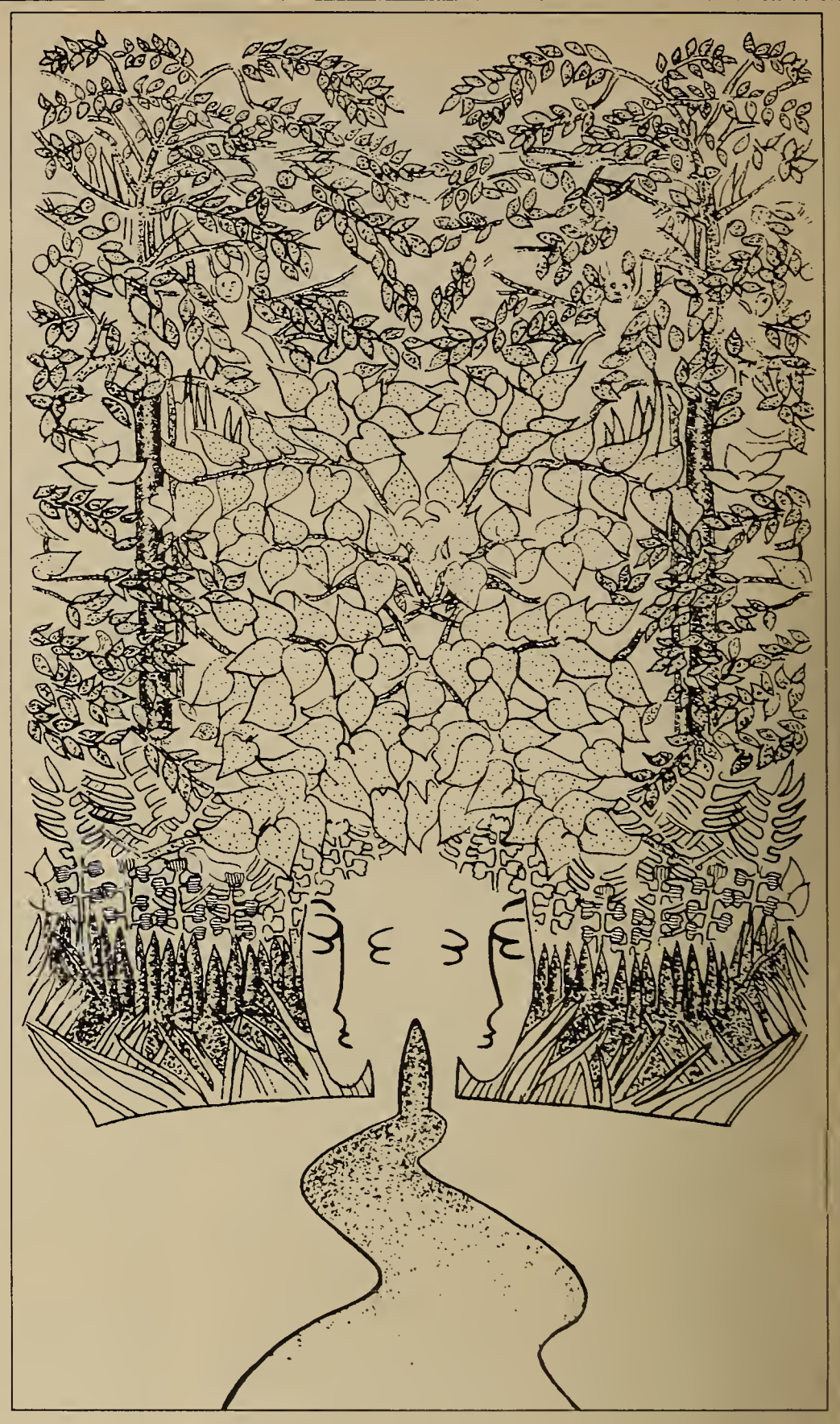
Attempts are being made today by cigarette manufacturers, "albeit rather slowly and unwillingly," to clean up cigarettes with filters and reduce tar and nicotine concentrations, and marijuana and cocaine users try to clean up their drugs. All of this is unsatisfactory, he says.

Dr Siegel adds that proper research and development may be able to produce a safe stimulant, sedative hypnotic, and euphoric hallucinogen to cover the three major types of psychoactive drugs which appeal to users.

The aim would be a drug which could not be abused.

He believes that in order to answer these needs "we need to learn more about chemical pathways and the ways of providing stimulations for these pathways in the safest possible ways. And this may not be a chemical way."

Dr Siegel was a speaker at the Cocaine Today conference in Santa Monica (See pages 2, 7, 10, 11, and **The Journal**, July.)



Siegel: '. . . It is not likely we can remove the curiosity to explore . . .'

THE BACK PAGE

Begin accepts heroin petitions from Walker.

Heroin part of pain-control study aimed at educating MDs

OTTAWA — Heroin will share medical scrutiny with other drugs as Canadian experts assemble to establish guidelines for the effective management of severe pain.

Physicians in Canada share a general "lack of knowledge" about pain control, and the expert committee's guidelines are to provide doctors with a therapeutic monograph on the varying efficacy of both non-narcotic and narcotic drugs — including heroin, Ian Henderson, coordinator of the committee, and director, Bureau of Drugs, told **The Journal**.

Formation of the committee came about, in part, as a result of a personal crusade by an Ontario physician seeking to have heroin legalized for therapeutic use in this country.

Since 1955, when Canada agreed with a World Health Organization (WHO) recommendation and banned all legal heroin imports, the drug has been legally unavailable to physicians. Thus, there is virtually no experience with medical use of the drug here, says Dr Henderson.

Ken Walker (alias Dr W. Gifford-Jones), author of the syndicated newspaper column *The Doctor Game*, recently met with Health and Welfare Minister Monique Begin to discuss legalization of heroin. He asked her for a change in legislation which would give the narcotic a status similar to that of morphine. (Morphine, a controlled drug, is available from physicians or from pharmacies upon presentation of a signed doctor's prescription.)

While morphine is effective in most cases, Dr Walker said heroin should be available as an option. "Two painkillers in the black bag are better than one," he said. "And in 10% to 15% of patients that require intra-muscular injections, heroin is better."

Heroin would be of particular value to patients dying of painful cancer, said Dr Walker, since their emaciated bodies make finding a muscle for injection difficult and painful. A smaller volume of heroin may be required as compared to morphine. He cited two studies — one from the Memorial Sloan-Kettering Cancer Center, NY, and another from Georgetown University, Washington, DC — which indicated heroin is two times more potent than morphine.

Ms Begin responded to Dr Walker's presentation — which included 15,000 signatures and 10,000 supportive letters — by agreeing to ask the WHO to reconsider the heroin ban. She said she would seek help on this appeal from her United States counterpart Richard Schweiker, health and human services secretary.

"I was definitely impressed with Dr Walker," said Ms Begin. "He wasn't doctrinaire. He was tolerant and explained his purpose which was the relief of pain. I agree fully with that issue."

But she said she would not recommend legalization of heroin on the basis of Dr Walker's presentation alone. "I can't base such a major decision on that petition."

In the meantime Ms Begin has charged Dr Henderson to prepare the therapeutic monograph on the management of pain with drugs currently at doctors' disposal. "The meeting opened my eyes on the fact that Canadian doctors don't know of existing licensed drugs that do the same as heroin," she said.

(See — Public — page 2)

Methadone another cancer analgesic?

By Betty Lou Lee

LONDON, Ont — Methadone, once hailed as a great hope in treatment of heroin addiction, is now receiving increased attention as an analgesic in the intractable pain of terminal cancer.

This interest in the United States comes at the same time as a Canadian movement to have heroin legalized for terminal cancer pain. (See related story.)

Ida M. Martinson, RN, PhD, director of research and professor of nursing at the University of Minnesota School of Nursing, Minneapolis, is encouraged by results with methadone in children dying of cancer.

She is a pioneer in home care for children with cancer, and reported on 10-year studies of these children at the annual meeting here of the Canadian Pediatric Society.

"With methadone and oral morphine, I'm not sure there's a need to have heroin," Dr Martinson told **The Journal**. "I think methadone really should be looked at. It's more cost effective, for one thing."

She is the principal author of an article on the use of methadone in childhood cancer (*American Journal of Nursing*, March, 1982).

Of 29 children given oral methadone, 28 got good pain control, after achieving only limited relief with a variety of analgesics and narcotics.

Most of the children had behavioral changes within 24 hours of the first dose. Parents reported they were no longer cross and irritable, they began to talk and move around, and were no longer in such pain they couldn't be touched.

(See — Advantages — page 2)

Vol. 11 No. 9 2nd Class Mail Reg No. 2776 TORONTO September 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Upheaval in Lebanon is creating drug enforcement difficulties.

RCMP spots increase in hash

Lebanon war fallout hits NA drug trade

By Mark Kearney

TORONTO — The war in Lebanon is creating problems for the Royal Canadian Mounted Police (RCMP) in the battle against drug trafficking, says Superintendent Rod Stamler, officer in charge of the drug enforcement branch.

Stamler: RCMP feels effects.

One result of the war is political instability and that has led to increased shipments of hashish to North America, he says. Lebanon is now the principal source country of hashish for the North American market.

"We feel that because of some of the political problems in that region of the world, it is difficult to coordinate law enforcement efforts and, consequently, hashish, perhaps even produced in surrounding areas, is brought into Lebanon and trans-shipped through other Mediterranean countries into North America.

"And the political instability in that region allows a breakdown in law enforcement efforts and priorities, and makes it easier for the traffickers to deal in large shipments."

Supt Stamler says RCMP enforcement concentrates on traffickers, sometimes starting with the "low level trafficker" and trying to work upwards into the major criminal organizations.

He says in some cases hashish and heroin are imported into Canada at the same time because the criminal group here that's importing drugs has connections with a particular source country or area. Once the drugs are in, they are distributed to various points in North America.

"In other words, the split comes after the drugs arrive here. They may be on the same vessel, in the same package, or in the same shipment."

While heroin and cocaine remain the branch's chief concerns, (**The Journal**, March) Supt Stamler says the market for "exotic blends" of marijuana, such as sinsemilla developed in the United States, has increased "dramatically."

I think there is now a demand for that variety, or those varieties," he says. "And they are being produced at large — everywhere where the weather, climate, and facilities permit — to the extent that a lot of people are getting into the busines."

Relatively small operations can produce millions of dollars, Supt Stamler says, but, as more individuals get involved with these exotic blends, the price will likely decrease. And because of the profits involved, he expects more people will get involved.

"The plant can be grown in a controlled environment with plastic and glass, and I think it can be grown as far north as the Northwest Territories and the Yukon."

Three traditional growing areas for marijuana in Canada are the eastern townships of Quebec, the Niagara Peninsula, and British Columbia. Supt Stamler says the amount grown was insignificant, the THC content was very low, and there was relatively little profit to be made.

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NEWS

Briefly...

CFL drug problems

TORONTO — Several Canadian Football League (CFL) players are upset with a recent decision by Commissioner Jake Gaudaur who has rejected a suggestion to study alcohol and drug abuse in the league. Former Toronto Argonaut Jim Corrigal suggested the problem was serious enough to warrant the CFL's setting up a means for players to obtain confidential guidance. Mr Gaudaur opposed the idea saying it was best handled at a club level and that "professional athletes are adults and must be responsible for themselves."

Triggering sunburn

INDIANAPOLIS — Popping pills and sitting in the sun don't mix. Roger Maickel, a pharmacy expert at Purdue University, says people taking drugs — even aspirin — for a chronic ailment can suddenly become allergic to sunbathing. There are 375 chemicals and drugs, including anti-inflammatories, antibiotics, and anti-convulsants, that can absorb ultraviolet light and trigger sunburn in people who've never suffered before. Women between 35 and 55 years who sunbathe and take such drugs are most susceptible, he says.

ADPA honor

WASHINGTON — Donald J. Ottenberg, MD, who retired this past summer as executive director of the Eagleville Hospital and Rehabilitation Center in Pennsylvania, has been honored by the United States Alcohol and Drug Problems Association. A resolution unanimously approved by the association expressed appreciation to the "kind and good man" for numerous contrihutions to the field of alcohol and drug abuse, his many years of service at Eagleville, and his help and guidance to various professionals in the field.

Druggist and patient

OTTAWA — Drs William Parker and David Yung of Dalhousie University, Nova Scotia, have received a $23,926 federal grant to evaluate the impact of community-based pharmacist counselling. Previous studies show that patient counselling by a pharmacist in a hospital has a positive effect on drug use and compliance with drug therapy. The two doctors propose to extend the research to a community setting and evaluate its economic feasibility.

Caffeine confusion

HULL UNIV, ENG — Contrary to traditional wisdom, coffee may not help drinkers sober up. In a series of eye/hand coordination tests, subjects who drank four screwdrivers performed more quickly and dextrously than those who drank four screwdrivers plus two cups of coffee. Dr Geoffrey Lowe, head of the study, admits eight subjects is a small group, and plans further tests with 96 people. But he allows himself a preliminary conclusion: While it's been assumed alcohol (a depressant) and caffeine (a stimulant) cancel each other out, Dr Lowe suspects that "together, they overload the brain and cause confusion."

Sidestream smoke, CA a case for strict laws in public places?

TORONTO — Non-smokers in smoke-filled rooms are being exposed to a powerful carcinogen in concentrations 50 times greater than mainstream (inhaled) or exhaled smoke, says a Health and Welfare Canada report.

The danger originates from sidestream smoke, the smoke that goes directly into the air from a burning cigarette, says Don Wigle, chief of the department's non-communicable disease division.

He says the carcinogen, N-nitrosodimethylamine (NDMA), is one of the most powerful known. A non-smoker exposed to air heavily contaminated by tobacco smoke (in a smoke-filled bar for example) inhales as much NDMA in one hour as a smoker does by smoking 15 non-filter or up to 35 filter-tipped cigarettes, Dr Wigle says.

In other words, the smoker who has a filter is better off than the non-smoker who is breathing the sidestream smoke directly, he says. However, smokers also have to worry about any sidestream smoke they inhale.

NDMA has produced cancer in all animal species tested and by various methods of exposure including inhalation of a single dose, Dr Wigle says.

A California study showed that non-smoking office workers who work in tobacco-polluted air for more than 10 years have impaired pulmonary functions, Dr Wigle says. Although statistical comparisons can be tricky, these non-smokers may be inhaling the equivalent of 10 cigarettes a day.

This information may be beneficial in getting substantial limitations on smoking in public areas, says Dr Wigle. However, he says it's also important that people are better educated about the dangers they may face from NDMA and other chemicals.

"What we need is to get non-smokers much more aware of what's happening," and to get them to speak out for better protection through non-smoking bylaws, for example, he says.

Public supports heroin use for terminal pain: Walker

(from page 1)

Dr Henderson said the committee will develop some "good, practical recommendations about how to use these drugs and when to use one over the others." And we'll look at whether there is a unique place for heroin in the doctors' armamentarium," he said.

A recent Canadian Cancer Society report, based on a review of the world literature on heroin use, said heroin has "no unique features to make it a necessary addition."

Dr Robert Macbeth, senior executive officer at the cancer society, said a committee of 20 experts could find no evidence to warrant lobbying for the legalization of heroin. He said concern over fostering abuse and addiction if the drug was diverted from hospitals and pharmacies to the street "predicated" the society's negative approach to heroin.

On the other hand, Ms Begin, who knew of the cancer society's statement, said she was not convinced that legalizing heroin for medical use would encourage abuse. "A lot of the negative guidelines from the WHO were connected to the criminal use of drugs. I'm not convinced that's a strong argument." She told Dr Walker, however, that "to legalize heroin would be attacking an institution."

Shortly after her meeting with Dr Walker, Ms Begin was called on to discuss the heroin issue in the House of Commons. Conservative MP (Member of Parliament) for Nepean-Carleton, Walter Baker asked her to refer the issue to a commons committee for full, public debate. The health minister refused, saying she preferred to leave it to the medical community. Mr Baker, however, promised to pursue the matter, possibly through a private member's bill.

In a recent survey of his constituents, Mr Baker found "overwhelming" support for the medical use of heroin. Of the 10,000 who responded to the questionnaire, 97% favored heroin treatment for pain in the terminally ill.

Meanwhile, the drugs and psychotherapy sub-committee of the Canadian Medical Association (CMA) is reviewing the issue, and is expected to make a report at the CMA annual meeting in Saskatoon later this month.

It is studying the relative effectiveness of drugs on the market, both singly and in combination; the relative knowledge of doctors about how to use them; and the regimens established in hospitals.

Dr Walker said he wondered whether the real resistance to legalizing heroin is made up of "the politicians, university professors, and doctors who don't want their good name associated with a bad street drug."

Walker: Armloads of petitions to legalize medical use of heroin.

D.A. Geekie, director of communications, said the CMA's official position to the LeDain Commission on the Non-Medical Use of Drugs a decade ago, was that the use of heroin where other drugs weren't available would be so limited, it wouldn't warrant the attendant risks of illicit use.

Mr Geekie said the CMA was not consulted when the Canadian government signed the WHO agreement.

Dr Walker's heroin crusade began early in 1979 when he first advocated heroin for pain relief in his newspaper column. Since then, he has written two other columns dealing with the same subject and received more than 10,000 responses. He claims only a handful have been opposed to heroin legalization.

Currently, Great Britain, New Zealand, Belgium, China, and West Germany among others allow heroin for medical use.

Superintendent Rod Stamler, officer in charge, Drug Enforcement Branch, the RCMP (Royal Canadian Mounted Police), said whether any of these nations suffers serious problems with abuse and criminality as a result is questionable.

He said the heroin addiction problem in Britain is widely recognized, but whether that is attributable to diversion of licit heroin is unclear.

In Canada, the heroin abuse situation is fairly stable at present, Superintendent Stamler told **The Journal**. His only concern, if it ever became available here, would be the security risks involved in protecting this "valuable commodity." Heroin commands a high price on the illicit market so he would expect theft and pilfering of the drug to increase. "The problem I see with heroin, as with any opiate, is with respect to diversion from licit to illicit sources."

Advantages in methadone as analgesic in cancer

(from page 1)

Doses ranged from 2.5 mg to 40 mg every four to 12 hours, with a typical dose being 5 mg to 10 mg every six to eight hours.

A co-author, Dr Richard YaDeau, of Bethesda Lutheran Hospital in St Paul, also reported "excellent pain control" among 40 adults with chronic cancer, 33 of whom were managed at home.

Although studies of methadone as an analgesic started when it was developed in the 1940s, interest in it centred chiefly on its use in addiction programs until the mid-1970s.

Dr Martinson said it has a number of advantages over other opiates.

It leaves the patient relatively clear-headed for the first six to eight hours after a daily dose, with some sedation later in the day which reduces anxiety and increases ability to sleep.

Withdrawal

Methadone tablets are less expensive than other oral narcotics for severe pain.

There might be a mild withdrawal syndrome, but the drug can be readily withdrawn when pain has abated.

The Minneapolis group found there was less nausea and vomiting than with some other narcotics, such as morphine, and this often subsided after initial doses, when the vomit centre was depressed.

NEWS

Pot outstrips alcohol among native children

By Mark Kearney

TORONTO — Marijuana use among native children in the United States is becoming more prevalent than alcohol use.

Fred Beauvais, PhD, says a survey among fourth to sixth graders in three tribes in the US shows an average of 37.1% had tried marijuana compared to an average of 35.9% who had tried alcohol.

"That's extremely high among fourth to sixth graders," he told **The Journal**. "A few years ago, we would never have predicted that marijuana use would rival alcohol use among Indian youth.

"Now, we don't hesitate to predict that lifetime prevalence of marijuana, in some age groups and locations, will actually exceed exposure to alcohol. We have further data to suggest marijuana will also be used more regularly and heavily than alcohol."

Dr Beauvais, a research associate at Colorado State University, says marijuana has become more available because it's relatively cheap, easily concealed, easy to use, and has a reputation for not being dangerous. He believes the problem will get worse because most reservations lack the resources to battle drug abuse. On the other hand, alcohol abuse, which is a much older problem, is starting to be countered, he says.

Dr Beauvais says problems on reservations seem to be about five years behind the rest of the country. That's why he expects the marijuana problem will continue in the near future.

However, he expects that problem may be replaced by increased use of cocaine and stimulants — the existing trend in the rest of US society.

Dr Beauvais and colleagues surveyed 3,600 young people on eight different reservations throughout the US. They also found that marijuana use among Indians was much higher than among non-Indians.

For example, 63% of eighth grade Indian children have tried marijuana, 46% can be classified as users, and 6.9% as daily users. "This rate of marijuana use is almost identical to that of high school seniors in non-Indian schools."

His data also shows that 62% of Indian youths who are marijuana users will use it in combination with alcohol. Dr Beauvais says one of the reasons for the high use among Indians compared to non-Indians is that life for many reservation young people is highly stressful.

"It is commonly acceptable that stress provides conditions in which drug use is likely to occur."

Dr Beauvais and colleagues, sponsored by the National Institute on Drug Abuse, have surveyed about 14,000 Indian youth since 1974.

Dr Beauvais says on reservations where surveys have been done, officials have used his data and tried to get resources to battle the marijuana problem. He says he's hoping to collect information on how some of the intervention programs are working and also to do follow-up studies on individuals to determine trends in drug abuse on the reservations.

Drug-wise US patients, physicians cutting back on R_x use

By Harvey McConnell

WASHINGTON — United States doctors have significantly reduced their prescribing of tranquillizers, sedative hypnotics, and sleeping pills in the past six years.

Studies by the US National Institute of Mental Health (NIMH) here, and the Institute for Research in Social Behavior in California, found the percentage of the US population aged between 18 and 74 years who are using psychotherapeutic drugs has fallen to 15.9% from 18.1%.

Prescriptions for tranquillizers dropped to 70.8 million in 1981 from 104.5 million in 1973 — the peak year. Prescriptions for diazepam have slid to some 31 million in 1981 from a peak of 62 million prescriptions in 1975.

For sleeping pills, prescriptions have dropped to 21.1 million in 1981 from more than 40 million in 1975. For the so-called "daytime" sedatives, such as phenobarbital, prescriptions have dropped to 9.6 million in 1981, from 21 million in 1975.

The reduction is not confined to the psychoactive drugs: prescriptions for such compounds as penicillin and compounds for heart disease have also fallen even though more drugs than ever are now on the market.

Michael Balter of the NIMH, who has carried out a number of studies during the past 15 years, said the decline in prescribing of psychotherapeutic drugs began in the mid-1970s when the side-effects of many compounds became obvious to doctors.

In the same period, Dr Balter said, there has been a major change in how the average US citizen views drugs and their use. Until the past 10 years, "Americans have not been used to the idea that there are risks and benefits to be weighed in drug taking.

"Now people have become aware of the risk part."

Sidney Wolfe, of the Public Citizen Health Research Group, a consumer protection organization, said his group "is very optimistic about the change." Dr Wolfe and his group have been active for a number of years in pressuring the US Food and Drug Administration and other agencies to limit or remove what they consider dangerous drugs from the market.

Now, Dr Wolfe believes, "there has been a tremendous turnaround in the past five to seven years."

He said that 20 years ago doctors knew little, and patients even less, about adverse drug reactions. Several groups of new drugs "were leaped on by doctors and patients without knowing how dangerous they were."

The report can be seen also as a tribute to the efforts Dr Peter Bourne made to cut such prescribing when he headed the White House Office On Drug Abuse during President Jimmy Carter's administration.

Until he was forced to resign in 1978, Dr Bourne warned doctors, and the medical profession in general, that unless prescribing of barbiturates and other psychoactive drugs were cut, stringent action might be taken by the government. Most of the decline in prescribing has taken place since then.

Teenage dealers suicidal

TORONTO — Teenage drug dealers may become "highly suicidal" because their illegal activities alienate family and friends, says Derek Miller, professor of psychiatry, Northwestern University, Chicago.

Drug dealers can be seen as "exploiters" by their peers, and therefore have no supportive social group to rely on. Their survival then seems to them to be quite irrelevant to others, Dr Miller noted in a special lecture at the American Psychiatric Association annual meeting here.

He also said suicidal adolescents often tend to have feelings of omnipotence. The abuse of toxic drugs, particularly LSD and other hallucinogens, often produces an acting out of an omnipotent wish.

"Omnipotence is reinforced by regressive drug abuse, and under the influence of hallucinogens the fantasies (being able to fly from high buildings for example) become delusions which may be played out in reality," he said.

A self-confessed bottle smuggler speaks out

By Wayne Howell

Ever since Toronto was awarded a major league baseball franchise in 1976 there has been constant pressure on the Ontario government to allow beer sales in Exhibition Stadium. Baseball is just not baseball without beer, goes the argument. Last month the provincial government finally succumbed and passed legislation allowing the sale of beer at professional sports events in outdoor stadiums.

What long-term effects this will have on the health and morals of the populace I cannot say. But personally, I think it is a good thing. I should add that I have smuggled liquid refreshment into Exhibition Stadium and it may be that a self-confessed smuggler such as myself has, by his flagrant disregard for the law, forfeited all right to make such a judgement. But hear my story, before you decide:

Some years ago I participated in a family outing to see a Blue Jays game at Exhibition Stadium. We were a happy little band when we started out. The only sour note came from my mother, who was well-acquainted with policies and procedures at the stadium. I could not, she said, take a bottle of orange juice for my infant daughter into the stadium. The guardians of the gate would confiscate any liquid-containing bottle, thermos, or tin that they could find as they rummaged through overcoats, back-packs, and handbags, in the manner of airline personnel looking for bombs. All potable liquids were *verboten*.

"No problem," I said, thinking that I would just buy what I wanted after we had passed the check-point. Impossible, said my mother. The only refreshment available was soda-pop. No juice, no milk, just soft drinks. My daughter would have to make do with carbonated sugar-water. I rebelled at this. At that stage in her life, my daughter was what you might call a primary abstainer. She had never tasted the tooth-rotting goodness of soda-pop and I did not see why she should be thrust into that world of caffeine and sucrose just to satisfy the liquor laws of Ontario. And so, I resolved to become a smuggler.

When my mother saw that I was adamant, she agreed to serve as technical adviser on "Operation OJ." (Despite the fact that she was a tea-totaller, she had picked up valuable intelligence during her previous visits to the stadium.) As the car bore down upon Exhibition Stadium, various strategies were devised. It was finally agreed that the offending liquid would be secreted in a thermos bottle and hidden in the folds of a rolled blanket. My mother was delegated to carry the contraband, since she was the least likely member of the family to arouse the suspicion of the stadium guards. (This was on the presumption that they, like airline security officers, had a "profile" of likely booze-smuggler types, and while my face might fit the profile, my mother's grandmotherly-innocent face most likely would not.)

I had not really taken my mother's tales of the Exhibition Stadium liquor police too seriously during the planning session in the car. But when we arrived at the gate of the stadium, a two-man team of brown-uniformed guards searched the back-pack, the handbags, and the diaper-bag with a diligence I had not seen since I had crossed the Allenby bridge from Jordan and came under the scrutiny of Israeli customs. But so intent were they upon the diaper bag that they failed to examine the rolled-up blanket. We made it. The ruse worked.

Alas, there is no such thing as the perfect crime. We discovered this soon after we took our seats. In our nefarious scheming to confound the authorities and transgress the law we had forgotten one vitally-important thing: Bertha Bunny. The stuffed rabbit which was my daughter's constant companion lay in the rear window of the car, back in the parking lot. My daughter made it clear that she wanted Bertha Bunny. A single by the Jays in the bottom of the first, and a rather spectacular double-play in the top of the second, did not distract her in the least. It soon became apparent that she could no more enjoy a baseball game without Bertha Bunny than Sparky Lyle could enjoy pitching in one without a mouthful of chewing tobacco.

"No problem," said I, "I'll just slip out and get Bertha Bunny." I retraced my steps back to the gate, where the brown-shirts were still at the turnstiles, rummaging through the handbags of latecomers. I checked to make sure that I had my ticket stub and then started to slip through one of the exits. But my way was blocked by a nimble brownshirt. Leaving and returning was *verboten* too. I explained about Bertha Bunny and my daughter's heartfelt need for the company of the stuffed rabbit but the booze-narc just gave me one of those "oh yea, sure buddy" smiles. The forgotten binoculars which was actually a cleverly-disguised liquor flask; the forgotten pillow containing a plastic bag of gin; the forgotten rabbit filled with rum — he'd heard and seen it all before. If I left I could not come back with Bertha Bunny. Rules were rules. Incredibly, I could not return even if I returned empty-handed. (This, presumably, was to prevent me nipping out for a drink in the parking lot and then returning to cause havoc among the paying customers.)

At this point I lost my temper and addressed the booze-narcs in rather ungentlemanly language. The brown-shirts responded in kind. Things went rapidly from bad to worse and the brown-shirts talked of calling the police: real police, not liquor police. Eventually I slunk back to my seat, a beaten man.

Needless to say, I did not enjoy the rest of the game and I never returned to the oppressive atmosphere of Exhibition Stadium. In later years, when I got the urge to take in a baseball game, I went to Olympic Stadium in Montreal. There you could bring your own orange juice, buy beer from roving vendors if you chose to, and bring in as many stuffed rabbits as you wanted.

NEWS

RESEARCH UPDATE

Coffee drinkers forge on

Drinking several cups of coffee per day seems to increase the risk of developing pancreatic cancer — the fourth most important cause of cancer death — suggested a study published last year in the respected *New England Journal of Medicine* and given wide publicity. Now, another study published in *NEJM*, suggests that few people took the results sufficiently to heart actually to change their coffee-drinking habits. A University of New Mexico research group led by Dr Jonathan Samet contacted 498 people in a telephone random survey and asked them if they were currently coffee drinkers (70% were) and if they had changed their coffee-drinking habits because of the suggested link between coffee and pancreatic cancer. Of the 348 current coffee drinkers and 51 former coffee drinkers surveyed, one person had been sufficiently impressed by the results to reduce consumption. Perhaps, despite the media attention, people hadn't heard of the results? Not at all — 58% of the people contacted were familiar with the study. Whether laziness, fatalism, or skepticism lay behind the survey subjects' apparent indifference to the findings was not a question the researchers asked.

The New England Journal of Medicine, July 8, 1982, v. 306:128.

Does diazepam affect driving?

There is a definite loss of road-tracking ability after as little as 10 milligrams of diazepam, says a Dutch research group which tested the effects of five different conditions (10 mg diazepam, 5 mg diazepam, placebo control, no-tablet control, and 1:00 am control) on the driving of nine skilled drivers. All the testing was done in good weather on straight stretches of road with which the drivers were familiar. There was a little weaving or "lateral variability" in the early-morning and 5-mg diazepam conditions, but eight of the nine drivers had significantly more difficulties driving straight in the 10-mg condition. In a few subjects, the researchers say, the amount of weaving in the 10-mg condition was "striking."

Science, July 2, 1982, v. 217.

Sobering up pill seems to work

Can a pill containing nothing but some amino acids, vitamins, sugars, and salts lessen the effects of alcohol on driving performance? It seems so, say Drs Ernest Noble, a former director of the US National Institute on Alcohol Abuse and Alcoholism, and Marcelline Burns, associate director of the Southern California Research Institute, where many drinking-driving studies have been done. The researchers base their claim on a series of double-blind, placebo-controlled studies that have been done with the pill, which is called Sober Aid. In one trial, 12 men who were legally impaired, with blood-alcohol concentrations averaging 1.4 mg/dL, showed significantly better car-handling performance after the pill than after placebo. In another, average reaction time in an attention test was nearly half a second faster. In a third test, drunk men taking the pill were significantly better at detecting peripheral signals. Sober Aid, which will probably be marketed as a food supplement, seems to have its effect by competing more successfully for brain-cell receptors than does alcohol. The result is that the person's BAL (blood alcohol level) is not changed in any way but performance at high BALs is improved.

Medical World News, June 7, 1982: 67-68.

Naloxone for alcoholic coma?

Patients can be brought out of an alcoholic coma by being given intravenous naloxone, suggest Drs Leonard Lyon and Jose Antony of Bergen Pines County Hospital, NJ, who report two such cases. In both cases, toxicologic screening confirmed that ethanol was the cause of coma. Noting that this report supports similar findings in a 1980 British study, an editorial in *The Lancet* says: "If time in hospital can be shown to be shortened, one might then be justified in recommending such an expensive drug. . . ."

Annals of Internal Medicine, April, 1982, v.96:464; and, *The Lancet*, July 10, 1982: 80.

That grass used to be greener

After seven or eight years of marijuana use, some of the bloom goes off the joint, indicates a study in which 100 young adults evaluated their reactions to marijuana, first in the early 1970s and then again five to seven years later. Ninety-seven of the subjects were located for the follow-up. They averaged 27 years at that time and all were still smoking marijuana, at least occasionally. A total of 105 effects, including both the desirable and the undesirable and those occurring during the drug high ("acute effects") and after ("chronic effects") were evaluated. Of 15 desirable "acute" effects (for example: increased alertness, relaxation, peaceful), seven occurred significantly less frequently at follow-up, and, of the remaining eight, all but one had declined. Similarly, of 10 desirable "chronic" effects (for example: mind clear, awaking refreshed), nine were occurring significantly less frequently at follow-up. There were few significant changes in the frequency of occurrence of the undesirable effects, though tachycardia, lightheadedness, and dry mouth were less frequent. This suggests that some tolerance may have developed, say Drs Ronald Weller of the University of Kansas and James Halikas of the Medical College of Wisconsin.

Paper given at American Psychiatric Association annual meeting, Toronto, May, 1982.

Austin Rand

Life-enhancing or destructive: being 'high' can be both

By Betty Lou Lee

HAMILTON — Describing someone as 'high' names a category of activity, but the experience can be life-enhancing, self-destructive, or anything in-between, says Calgary educator Ken Low.

"An intoxicant is a tool for getting high, but so is (Toronto's) CN Tower," he told the annual Institute on Addiction Studies here.

People like to get high because things look different, and they want things to look different because "the human mind can stand anything but boredom."

A person 'high' on the CN Tower could make a nuisance of himself with irresponsible behavior such as dropping things over the edge. He could experience mirth from the sudden change of perspective, when the cars below look like toys.

He might have an esthetic reaction from looking at the scenery, or he might begin asking questions and analyzing to get a better understanding of the lay of the land.

He might "freak out" at how high he is, and drop to the floor, screaming, or experience fear or minor discomfort. Realizing he's only six inches from infinity, he might go over the edge.

Mr Low is coordinator of action studies with the Calgary board of Education, and his focus is primary prevention of self-defeating behaviors.

"Kids ask me what's the most dangerous drug, and the question makes no sense. Are buzz saws more dangerous than paring knives? It depends on the skill and wisdom of the user, availability, and intention."

There are more accidents with paring knives, but buzz saws are inherently scary so people take time to find out how to use them.

"Anytime the power of a tool outstrips the power of control, you can have problems. But it is possible to use any intoxicant without sustaining damage," Mr Low said.

In designing prevention approaches, those of abstinence and limited use undermine one another, so neither is effective. Those who advocate abstinence say the tools are far too risky.

"It's a fail-safe approach, because you can't fall off mountains if you don't climb them. But many push it too far, and claim that climbing mountains causes problems. With the abstinence approach you are saying the limits of use — style, extent, and dosage — aren't worth examining."

The limited use approach maintains "there are things you can do to stay within limits, and here's what they are. There are boundaries that if crossed, result in problems."

The popular idea that a drug takes over and the user can't stop taking it flies in the face of epidemiological evidence, Mr Low said. "Two-thirds of heroin addicts stop without intervention."

Many United States veterans used heroin at addictive levels in Vietnam, and major problems were expected when they returned, but many had no interest in the drug back home.

Dr Low said an explanation for this lay in rat experiments by psychologist Bruce Alexander at Simon Fraser University in Vancouver (**The Journal**, Feb, 1980).

For 35 days, morphine was added to the drinking water of two rat populations: one in individual cages, one in a "rat park" with lots of space, both genders, and junk to hide in and chew on.

Then given a choice of plain or morphine water, the park rats chose plain, the caged, the drug.

"In the park, they didn't want to stay stoned, because it was tough to mate, run around, and stake out territories . . . If you're living in a cage, how do you spend your time? You have six inches by six inches of space, a water spout, and food pellets. You can't even play with your turds because they fall through a screen."

Mr Low said the biggest drug problems are in "caged populations:" native and senior citizens, especially those in institutions.

Alcoholism is soaring in countries with repressive governments, and he thought more centralized authority, "more cages," might lead to an increase in drug problems in democratic countries.

Little 'highs' can impinge on efficient functioning

HAMILTON — There are 11 activities people of all cultures engage in when they don't have anything else to do, says Ken Low, coordinator of action studies, Calgary Board of Education.

They require little or no knowledge, stamina, or skill, and they provide small 'highs.'

"They're so easy to do they can creep up on you until you spend all your time at them . . . you have to watch they don't take over your life."

They are:

- **napping**
- **eating**
- **listening to music**
- **easy conversation**
- **use of intoxicants, including smoking**
- **courtship activities, such as holding hands**
- **simple movements (fidgeting, strolling, rocking a chair)**
- **day-dreaming**
- **watching anything that moves — water, people, television**
- **grooming activities — combing, scratching, pinching 'zits'**
- **reading**

"Eating cheesies can give a little high. Talking to someone at the same time gives a little more. Add music, beer, holding hands, and looking at other people, and we call it a party."

Education may not be enough

Smokers ignoring risk factors

TORONTO — Educating smokers about the risks of using tobacco may not be having the desired effect of encouraging them to quit, says a biostatistician with Health and Welfare Canada.

Doreen Van Toever says a recent Gallup poll of young people shows more than three-quarters of them were aware of various non-smoking ads but there was no difference between smokers and non-smokers.

"That's extremely interesting," she says. "It seems to show that the idea of educating smokers (about the risks) is a simplification (of the solution)."

The poll of 1,544 young people between 12 and 19 years showed that 22% smoked cigarettes daily and that one-third of these smoked a pack a day or more.

Mrs Van Toever says the poll suggests that even though young smokers are aware of the risks of such things as cancer, that doesn't seem to have been enough to convince them to quit. In many cases the smoker doesn't see himself as personally being at risk.

Future polls should examine the social norms that exist for smokers and users of alcohol and other drugs, Mrs Van Toever told **The Journal**. If basic educational campaigns aren't having enough effect on smokers then perhaps other avenues should be explored.

Advertisements aimed at various role models for these young people may be one way to shift attitudes away from smoking, she says.

Drunk's sky folly nets fine

BRIGHTON, ENG — A Briton who got drunk on a New York to London flight and so disorderly and abusive the captain considered diverting the DC10 flight has lost an appeal against fines of £750 ($1,590).

A 34-year-old-salesman, was fined £500 for imperiling the safety of the Laker Airways plane in January and £250 for refusing to obey orders from the captain. Brighton Crown Court dismissed his appeal that the fines were too harsh.

The court heard that the man made abusive remarks to women flight attendants, wandered about the plane with a drink in his hand, flicked cigarette ash on the carpet, fell across another passenger, and threw his breakfast into a bin.

Curtly dismissing the appeal, the judge said these were serious matters on an aircraft, and the lower court "had to make it clear that behavior of this kind deserves a heavy penalty."

Califano returns to aid DC drugs, sex inquiry

WASHINGTON — Joseph Califano, controversial United States secretary of health and human services during President Jimmy Carter's term of office, has agreed to become special counsel for a Congressional investigation into a major drugs and sex scandal on Capitol Hill here.

He was asked to take the job by the Democrat-controlled US House of Representatives ethics subcommittee. In the way of many Washington officials, Mr Califano also served in the Lyndon Johnson administration and most recently did a study of substance abuse for New York State.

Mr Califano said that after the 18-month study, he concluded drugs such as heroin, cocaine, and alcohol have become "America's number one health problem."

While he was health secretary for President Carter he earned the undying emnity of the tobacco industry, and its Congressional supporters, by vigorously pushing anti-smoking campaigns and calling cigarette smoking "Public Health Enemy Number One."

The House investigation will be separate from that now being carried out by the Justice Department into the allegations of a drug and sex ring (**The Journal**, Aug).

The ethics committee has been empowered to carry out a broad investigation into charges that some Congressmen may have used cocaine. There are also charges some of the Congressmen tried to solicit sexual favors from teenage male pages.

The Justice Department is looking into the criminal aspects of the situation: allegations that pages were promised promotion in return for sex, and that a cocaine ring distributed the drug among legislators and their aides on Capitol Hill.

Mr Califano was fired by President Carter after a shakeup of his cabinet in 1979. During his reign, Mr Califano tried to revamp the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) by forcing out Dr Robert DuPont as head of the National Institute on Drug Abuse and Dr Ernest Noble as director of the National Institute on Alcohol Abuse and Alcoholism.

Califano: Controversial health watchdog for US presidents.

GILBERT

'. . . who cares whether a rat melts or shivers when a tone sounds?. . .'

Conditioned responses and drug abuse

By Richard Gilbert

As controversy swirls around the validity of the evidence on controlled drinking, a related and more fundamental argument is going on in the scientific literature, one that also touches the Addiction Research Foundation (ARF) in Toronto. It concerns the responses that get conditioned to environmental stimuli during drug administration, and their possible role in excessive drug use.

The second controversy, I hasten to add, has none of the drama aroused by the claim by Mary Pendery and her colleagues that 20 alcoholic subjects who had been reported by Mark and Linda Sobell to have been trained to control their drinking had, in fact, continued to use alcohol excessively (**The Journal**, Aug). There are no press releases, lawyers, or external review committees. The debate around the second controversy is being conducted in the pages of the scientific literature in what used to be called a gentlemanly fashion — conducted, that is, with courtesy and decorum.

"Gentlemanly" is no longer an appropriate word, not the least because one of the antagonists would surely object. She is Jane Stewart, professor of psychology at Concordia University in Montreal. Dr Stewart's latest contribution to the debate is a manuscript written with two colleagues and entitled *The role of unconditioned and conditioned drug effects in the self-administration of opiates and stimulants*. The manuscript summarizes her previously reported work on this topic. It takes a swipe at explanations of compulsive drug use, and of relapse to compulsive drug use, that emphasize the avoidance of withdrawal symptoms.

Compensation

One researcher who has suggested a role for the avoidance of withdrawal or withdrawal-like states in excessive drug use is Shepard Siegel, professor of psychology at McMaster University, now spending a year at the ARF in Toronto. Dr Siegel has drawn attention to "compensatory" responses that become conditioned to stimuli that regularly accompany drug administration. One example, researched by Dr Siegel, is based on the well-known phenomenon that alcohol causes a decrease in body temperature in rats (and in humans too). If rats are injected with alcohol in a distinctive setting, the stimuli associated with alcohol soon come to elicit an *increase* in body temperature. It is as if the body were preparing itself for the alcohol onslaught by taking anticipatory, compensatory action, triggered by the stimuli that usually precede drug injection.

Dr Siegel has suggested that drug withdrawal symptoms are often the same as these compensatory responses, including the craving that may cause relapse to excessive drug use after abstinence (**The Journal**, Dec 1981).

Dr Stewart believes that it is another kind of conditioning effect that sustains drug use. She notes that the great Pavlov himself, in his original work on conditioning, discovered that stimuli paired with morphine injections soon begin to elicit responses resembling the effects of the morphine injections. Later work in this vein showed that a bell that had been paired with morphine could, presented alone, reverse the lowered body temperature that occurs during morphine withdrawal. Dr Stewart argues that stimuli paired with drug administration come to evoke "a central neural state that could act, as injections of the drugs themselves appear to do, to increase the salience of drug-related thoughts and stimuli."

Contradiction

So, here we have apparently contradictory findings as to what happens when stimuli are paired with drug-taking. Some researchers, including Dr Siegel, emphasize effects opposite to those of the drug. Other researchers emphasize effects similar to those of the drug. Both sets of researchers believe that theirs are the important effects.

The first question to be resolved is, are there two kinds of effect? Dr Stewart's own data indicate that there are. The key study was reported by Roelof Eikelboom and Dr Stewart in the journal *Psychopharmacology* in 1979. Rats were kept in a distinctive box for two hours and then transferred to another distinctive box where they were given a morphine injection at the beginning of a three-hour stay. This was done daily; then the morphine injections were discontinued. The preinjection box elicited hypothermia, an effect opposite to the normal effect of morphine, which is to raise body temperature. The injection box elicited the normal hypothermic response to morphine, even in the absence of the injection.

These data, say the investigators, demonstrate that complex conditioning effects occur when morphine is administered. Both morphine-mimicking and morphine antagonistic effects can be observed, even in the same experimental situation.

Later work by Eikelboom and Stewart extended the findings to a quite different drug, amphetamine, and suggested that the drug-like effect is more robust than the antagonistic effect.

Of course, discovering that the drug-like effect was stronger was grist to Dr Stewart's mill, but these are not the only data she adduces. As well as offering some fancy neurochemical reasoning, involving dopamine release in the ventral tegmental area of the brain, Dr Stewart draws attention both to the 'needle-freak' phenomenon and to the uncontrolled drinking that alcoholics engage in.

Needle freaks

Needle freaks get a kick out of injecting an inert substance. In one study, detoxified former addicts reported "opiate-like euphoria" when allowed to self-inject saline under semi-naturalistic conditions. This may not be the same phenomenon as the reversal of withdrawal-induced hypothermia mentioned above, which occurred in animals made dependent on morphine. Dr Stewart emphasizes that needle freaks are not necessarily dependent on a drug. She argues, nevertheless, that the phenomenon is a conditioning effect, and, moreover, one that illustrates the importance of conditioned drug effects.

Indeed, it is difficult to imagine how the needle-freak phenomenon can be interpreted in terms of conditioned compensatory effects, unless it is argued that former addicts do it for the taste of withdrawal rather than for the taste of the drug that once dominated their lives.

Uncontrolled drinking occurs when a drug does not appear to satisfy the user but rather stimulates further use of the drug. It is a characteristic of many heavy drinkers, and it is a reason for advising former heavy drinkers to abstain altogether: one drink will, for these people, inexorably lead to another.

There is one experimental demonstration of the effect (one drink leading to another) in human subjects. Dr Stewart has provided a rigorous demonstration of the effect in rats, in an article that was written with Harriet de Wit and appeared in *Psychopharmacology* in 1981. Rats pressed a bar for a shot of cocaine directly into the jugular vein. Then the cocaine infuser was disconnected, with the not-surprising result that barpressing ceased. Finally, a 'free' shot of cocaine was given, with the result that barpressing started again, albeit temporarily because no more of the drug was delivered. Barpressing was also reinstated by a tone stimulus that had been paired with the cocaine infusions.

As well as providing further evidence of a conditioned, drug-like effect, this study, says Dr Stewart, shows how a drug "generates a positive appetitive state that maintains drug-taking behavior."

Circularity

The problem with such an argument is that it is essentially circular. The reinstatement of drug-taking behavior is explained in terms of a positive affective state, which we know about mainly because the behavior is reinstated.

The reinstatement of the drug-taking can be explained equally well (and with equal circularity) in terms of conditioned antagonistic responses. The circumstances of the reinstatement of drug delivery, or even the delivery itself, could elicit the antagonistic response because of prior association with the drug's effects. The conditioned response, in the form of craving or some other state of deprivation, could cause the restoration of drug-seeking behavior.

The relative importance of the two kinds of conditioned response in drug abuse in general, and in relapse to uncontrolled drinking in particular, will be a subject for hot debate in the scientific literature during the next few years. Will the arguments matter to drug abusers, or to the people who will be trying to help them? The details will not matter — after all, who cares whether a rat melts or shivers when a tone sounds? — but the fact of the debate and its outcomes will likely be of profound importance.

Each new subtlety that is discovered about the involvement of the environment during drug administration helps to strengthen arguments that drug dependence is not a simple matter of pharmacology and physiology but a complex interaction between the abuser's body and the world around it. A decorous debate about the roles of the various conditioned responses in drug abuse will add much to our understanding.

NEWS

Budding physicians ripe for drug abuse need courses in prevention

Hsu and Kay: Students vulnerable.

By Mark Kearney

TORONTO — An ounce of prevention is needed to counteract the serious problem of impaired medical students, says an Ohio doctor.

Jerald Kay, director of medical student education, department of psychiatry, University of Cincinnati, says a program outlining the complexities and stresses of being a physician should be "an integral part of every freshman, medical-school orientation week.

"The process of acquiring greater sensitivity and comfort with one's own professional habits, and that of the impaired colleague, ought to be initiated during the first week of medical school," he says.

Such a program would let budding physicians know the enormous intellectual demands of the freshman year, the quantity of material that has to be mastered, and the stresses and strains that will follow once they become doctors.

Studies have shown that alcohol and drug abuse, depression, and personality disorders are "not uncommon among medical students," Dr Kay told a symposium at the American Psychiatric Association annual meeting here.

He says the preventive program isn't an attempt to intimidate or frighten new students but to "encourage an acceptance of the dangers as well as the rewards of medicine."

Dr Kay: "Introductory psychiatry and behavioral sciences courses would do well to amplify . . . the psychosocial stresses attendant to becoming a physician. Poor health habits associated with medical habits, the strains of medical marriage, exaggerated patient- and self-expectations, to name but a few, belong in such pre-clinical classes."

He says peers usually know first whether any fellow students are impaired. Small discussion groups with the aid of a faculty adviser can work to detect problems early, and ensure that help can be provided.

What is necessary, he says, is "the establishment of a more open process of peer discussion of the impaired medical student, thereby providing students with an early model for addressing similar concerns during later professional life. Such a model would not only provide skills in identifying impairment, but also attend to the dysfunctional attitudes that often inhibit seeking of professional assistance."

Kirby Hsu, a University of Toronto psychiatrist, said at an earlier session that one study shows that anywhere from 10% to 30% of medical students seek help because of impairment. Amphetamine use, especially among first year students, is also common, he says.

Dr Hsu says medical school can be competitive, and requires long hours of work at the expense of a person's health or family. The nature of the profession tends to make some medical students and doctors believe it's wrong for them to become vulnerable or sick.

"We are just as vulnerable. How many doctors believe it?" he asked.

Dr Hsu says it's important for doctors and medical students to become aware of the risks of the profession for substance abuse or other personal problems. A forum has to be provided where physicians may speak freely and confidentially about possible difficulties.

Any drug will do for abuser's repertoire: study

By Lillian Wylie

MONTREAL — The typical pattern of drug progression is cumulative; as a user adds to his drug repertoire, involvement with earlier drugs also tend to deepen, says Stan W. Sadava of Brock University, St Catharines, Ont.

"Thus, the stages or 'stepping stones' of drug use are not primarily the substitution of one drug for another," Dr Sadava, a social psychologist, told the annual meeting here of the Canadian Psychological Association.

The literature shows impressive evidence that the user, when introduced to a new substance, adds it to his expanding drug inventory, he said.

"Considerable research has focused upon the polydrug abuser, one who shows no particular preferences but, instead, attempts to alter his state of consciousness with almost any available drug."

Polydrug abusers were defined as those who had used, at least 10 times each, at least three of six different types of drugs (ie, stimulants, depressants, cocaine, opiates, hallucinogens, Darvon, etc) but not including cannabis and alcohol, he said.

One large-scale study of polydrug abusers in the United States showed concurrent use of up to 15 psychoactive substances at least once per week, Dr Sadava reported.

"In our research of the literature, three fundamentals are startlingly clear," he said:

- Drug abuse is not a simple linear function of drug-using behavior;
- When one drug is used more heavily, a greater variety of other drugs tend to be used;
- When a more dangerous or less common drug is used, the more common drugs are used more heavily.

"While some studies define multiple use in terms of specific drugs, others define it in terms of drug categories," Dr Sadava said.

"Thus, LSD, PCP, and mescaline may be three drugs or one type. While most studies include alcohol, few include caffeine, tobacco, prescribed psychoactive drugs, and 'over-the-counter' medications. The combined mathematical and pharmacological possibilities are mind-boggling."

Data collected show substantial correlations between heavy or problem drinking and extensive drug use. Problem drinkers tend to use marijuana more heavily than non-problem drinkers. However, while heavy drinking is a precursor to marijuana in adolescents, the latter does not replace the former.

Chronic drug interaction is another important consideration, he said.

"Prolonged exposure to one drug may affect reactions to another drug. For example, alcoholics tend to manifest increased sensitivity to oral insulin and certain anticoagulants."

Cross-tolerance to drugs may be functional, eg, decreased central nervous system sensitivity, or dispositional, eg, where the amount of drug directly available to the site of action decreases. On the other hand, he said, both types of cross tolerance may develop. For instance, alcoholics are less sensitive to barbiturates.

Calling on psychopharmacologists to play a more active role, Dr Sadava said: "The nature and extent of interactions make psychopharmacology an important consideration in the design of any research on drug problems."

Acceptance an 'uphill battle'

Methadone therapy still contributes

By Pat Ohlendorf

TORONTO — Methadone maintenance, still a controversial treatment for heroin addicts after 15 years, has received a belated stamp of approval from the prestigious United States Committee on Problems of Drug Dependence.

Meeting here in late June, the committee awarded the Nathan B. Eddy Memorial Award for excellence in research in drug abuse to Vincent P. Dole and Marie E. Nyswander.

The husband-and-wife team developed the treatment at the Rockefeller Institute in New York in 1964, and have continued clinical research in the area since then.

Dr Nyswander told **The Journal**: "It was a complete surprise. It's a great honor to be acknowledged by this ranking medical group in the field of addictions.

"If you live long enough, everything comes to you," added Dr Nyswander, who, in 1955, startled the committee by suggesting heroin addicts should be treated rather than jailed.

Dr Leo Hollister, of the Veterans Administration Hospital, Palo Alto, Ca, who presented the award, said the delay in recognizing methadone maintenance was "not due to any doubt about the modality of treatment or the value of (Dole and Nyswander's) contribution." It was simply a matter of older scientists "lined up" for the award, which has been given for only eight years.

Previous Eddy awards have gone to basic science research. "This is the first award for truly clinical work," said Dr Hollister. He said in future he expects the committee will recognize as many clinical as laboratory contributions.

Crime rate

Ed Senay of the University of Chicago told the meeting: "Methadone maintenance has been evaluated more than any other human service modality with the possible exception of psychotherapy." It has been shown to be safe, he said, and the health of addicts improves tremendously when they're switched from heroin to methadone.

Methadone maintenance also contributes to a decrease in the crime rate among addicts, said Dr Senay. "For this alone, Drs Dole and Nyswander deserve our highest awards."

But it has been, and to some extent still is, an uphill battle to gain widespread acceptance for the treatment, said Dr Senay.

For years methadone workers have been "reacting to attacks by the media, legislators, interrogators, inspectors, commissioners . . . enough to give Kafka material for two or three more careers."

One reason for the controversy, he said, is that "those in the alcohol treatment community tend to be biased against the concept of legal substitution, feeling it's like giving an alcoholic bourbon.

"Ideally, one would wish for a drug-free state, but to many thousands of addicts this is as yet an unreachable goal."

That "wish" is part of the reason methadone maintenance has not been as popular in Canada as it has in the US, says Ian Henderson, director, Bureau of Drugs, Health and Welfare Canada.

At the meeting, Dr Henderson pointed to "a basic difference in philosophy" on methadone between the two countries. In Canada, methadone is most often used for short-term therapy, to aid detoxification, rather than for long-term substitution for heroin.

Different approaches

Another factor in the difference in approach is Canada's heroin addict population is perhaps not large enough to justify the expense of long-term maintenance.

As for the future of methadone maintenance, Dr Senay pointed to the need for further research in high dose vs low dose programs, because drug abuse habits have changed since 1964, when the treatment began. Addicts are moving from using heroin as sole drug to using it in combination with other drugs, particularly alcohol and cannabis. The training of paraprofessionals involved in maintenance programs should also be improved, recommended Dr Senay, with licensing and certification becoming mandatory.

Alc problems to cost Ont $734 million

Birtch: Treatment can save province money.

HAMILTON — Residential treatment for alcoholism will cost about $41 million in Ontario this year, but society will pick up a tab of $734 million in alcohol-related problems.

That includes $528 million in medical treatment of injuries and sickness, $131 million in decreased productivity, $5 million in lost time, and $70 million in law enforcement.

These estimates were presented to the 23rd annual Institute on Addiction Studies here by George Birtch, chaplain at the Donwood Institute, a Toronto addiction rehabilitation centre.

In contrast, Dr Birtch said an economic analysis of the treatment of 180 clients in an evening, out-patient program showed savings of about $900,000 a year.

This included savings of about $98,000 to the Ministry of Health, about $6,000 to the judicial system, and the rest to the private sector.

Alcohol and drug clients in this program pay a fee for it — it is not covered by the Ontario Health Insurance plan. Dr Birtch said the Donwood's success rate is due in part to earlier intervention: Most of those taking part are still working, "and their minds are working."

FEATURES

High school ousts drugs, scores academically

By Harvey McConnell

SANTA MONICA, CA — High schools where there are severe drug problems among the students can be turned around by simple, straightforward methods.

This is the experience of William Rudolph, who in five years as principal, has seen North Side High School in Atlanta, Ga, end widespread drug use among students, win recognition for scholastic excellence, and train several possible Olympic athletes.

Mr Rudolph says this has been accomplished by spelling out policy plainly for students, parents, teachers, and administrators, and without police help or grants of any sort.

"What we have done can, with modifications, be applied to any school in this country," he believes.

Mr Rudolph arrived at the high school in the 1970s at a time when parenting and education "had allowed relationships with young people to become ambiguous at best and permissive at worst."

Students at North Side showed some of the symptoms. Drug use was endemic, marijuana plants grew in the library, and, at lunch time, only about 250 of the 1,400 students could be accounted for.

There were nine physical education teachers and no physics teachers, the chemistry teacher did not have enough students for a full day of courses, there were few extra-curricular activities, and there was a high tardiness rate.

The school represents a cross-section of Atlanta, with students from various ethnic, racial, and economic backgrounds, and with a complex system of values.

The past five years have seen consecutive academic growth; enrolment has increased 300% in new physics classes and 100% in chemistry classes, and 57% of the students now study for at least two years, and generally four years, one of five foreign languages offered.

Among 1982 graduates, only three had not been lined up by graduation for jobs, enlistment in the military, or enrolment in higher education. The school recently received a $10,000 award from the Rockefeller Foundation for academic achievement.

Mr Rudolph says there has been only one drug-related incident in the just-completed school year, three the year before, and five the year before that.

> '. . . We don't have 14-year-olds telling us what to do, parents are beginning to retain control of their children, and children respect the word 'no' . . .'

The process of changing the situation has been simple and straightforward, although not necessarily easy, he says. It requires effort by the administration, staff, "and an ingredient which had been left out, the parents."

Mr Rudolph says most educators "only allow parents to have decisions on situations where they don't care where the decision goes. There is a vested interest in the educational system to exclude parents."

Mr Rudolph believes the North Side system involves accountability without blame, and a clear definition of what the school expects from staff and students. The school produces a student handbook, another one for staff, and a newsletter for parents.

Consquences — both negative and positive — of a particular action are made very clear. "Consequences are what most parents are shaky about and many try to straddle the fence from both sides."

Students were told the consequences of drug use would be arrest, and the consequences of being late would be detention.

Mr Rudolph: "I am an educator, not a policeman, not a counsellor, nor into treatment." He knew little about chemical dependency when he took the job but learned quickly through the emerging parents' organization in Atlanta.

After three years, he says, "we don't have 14-year-olds telling us what do do, parents are beginning to retain control of their children, and children respect the word 'no'."

Mr Rudolph says he never asked, or wanted, his teachers to be policemen. "I asked my teachers to teach five periods a day. They had no frivolous duties, no policing." They were not asked to deal with intoxicated students or even to suggest they were intoxicated. If a teacher noted a student seemed to have problems in the class, the situation was reported to the administration, who dealt with it.

"I didn't ask my teachers for support. They are employees of the school system, and I insisted on it."

When a student is found intoxicated, parents are telephoned and asked to come and collect him or her. "We tell them their child came to school, is unable to function, and we would like them to come and get him."

Mr Rudolph tells parents he is sorry the student is in such a condition, but he does not want him or her to return to school until the problem is resolved. He is ready to make any referral the parents request.

Rudolph: An educator — not a policeman.

Mr Rudolph: "I tell them they should do whatever they think needs to be done for the child, and that my responsibility is to give them an education.

"I expect a child to come to school who is disciplined. My responsibility is to deliver an education. I don't expect to have to spend my time disciplining a student. That is the responsibility of a parent."

Mr Rudolph's school now has 36% fewer teachers than when he arrived, although during the shakeup he had to fire only two of them. Some resigned, some moved, and others retired.

As for teachers who do not wish to cooperate in such efforts, Mr Rudolph notes: "Those people who say teachers cannot be fired or dismissed don't know their law, or are unwilling to make the effort."

Mr Rudolph was a speaker at the Cocaine Today conference in Santa Monica (**The Journal**, July, Aug).

Alcohol classes keep teens off court dockets

By Mark Kearney

TORONTO — A young person is found guilty of an alcohol-related offence. In most places he is sent to jail or put on probation, often with little rehabilitation included.

In Newton, Ma, however, he would attend Alcoholics Anonymous (AA) meetings and therapy sessions and, in lieu of sentence, have the chance to earn a credit toward his high school diploma.

That's what makes the Newton Youth Alcohol Program original, says coordinator Joan Green. The program brings together the court and school systems, and counsellors and parents, in an effort to ensure these teenagers don't grow up to be adults with a drinking problem.

Although the program has been in operation for two years "we're still getting off the ground," Mrs Green says. Recent and more extensive media coverage about teenage drinking problems has helped but "it is getting better because the problems are getting worse."

A main goal of the program, established by Mrs Green, Arthur Wallace, a school teacher, Matthew Green, a counsellor, and District Court Judge Monte Basbas, is to provide information about alcohol and help students realize the problems it can create.

Some clients have had drinking problems since they were nine and 10 years old and yet they don't seem to realize they have a dangerous lifestyle. "They say 'I have fun drinking so why should I stop'," says Mrs Green.

However, the program is designed not to stop the students from drinking (because of the difficulties involved) but to provide information and education, she says.

"If I put into someone's head that there is a way out (of the heavy drinking lifestyle) then I've done something."

Most of the teenagers in the program have appeared before Judge Basbas following their arrest for drunk driving and/or other criminal offences in which alcohol played a role. If sufficient facts are found against the young offenders, the judge sends them to the youth program provided they are under 22 years old and an area resident.

> '. . . The problems of teenage drinking will continue as long as alcohol is seen as a symbol of adulthood . . .'

The teenagers go through the program for the same length of time as their probation would be — about a year on the average, Mrs Green told **The Journal**. During that time, the offender has to attend two AA meetings and one group therapy session a week. Regular attendance and involvement in discussions are what earn the high school credit, an added incentive to the students.

During group sessions, personal feelings and attitudes to alcohol are discussed. The therapists avoid being judgemental but tell the students from the start that if they miss the sessions, attend drunk or 'high,' or are disruptive, then "it's back to the court."

The program handled eight cases in its first year (1980-81) and 21 up to June of this year, the majority of the clients being male. More females are being included in the program each year, but in many cases police are less likely to arrest a young girl who is abusing the drinking laws, Mrs Green says.

Judge Basbas told **The Journal** he's enthusiastic about the program because it allows adolescents to be involved in sessions with peers. In other programs where adults are present, teens often get pushed into the background, he says.

It's important that even first-time offenders be involved in the program because of the benefits they can derive, Judge Basbas says. "It's absolutely necessary, even if he doesn't have a drinking problem, because he has to be educated."

Judge Basbas believes the problem of teenage drinking will continue as long as alcohol is seen as a symbol of adulthood. That's why he would like to see the program extended throughout the state, the rest of the United States, and other countries.

According to the latest statistics, 51% completed the program successfully, 20% graduated from high school, and 6% are college bound. Of the total, 13% committed crimes while in the program.

Mrs Green says she's pleased with the success but would like to do a follow-up study in five years to find out how the clients have progressed. Many students in the program seem to have developed new attitudes to drinking and felt an attachment to the sessions, she adds.

There may be some difficulty in setting up the program elsewhere, she says, because an organization has to have credibility in the community to convince schools and courts to participate. However, once established, costs are low. The Newton program costs the equivalent of two-and-one-half salaries.

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Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

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Employee assistance is not new to Ontario gov't

The article, Union/gov't develop EAP for Ontario's civil servants (**The Journal**, June), fails to acknowledge the services already in place and available to government employees.

The new program described is an alternative program for government employees in the Employee Advisory Service, Employee Advisory Services Branch, Ministry of Government Services. For 16 years this unit has been providing professional and confidential counselling to Ontario public servants throughout the province who voluntarily seek assistance. Confidentiality is the keynote for all Employee Advisory Service programs which include counselling and education, day care counselling, rehabilitation, management consultation, and training.

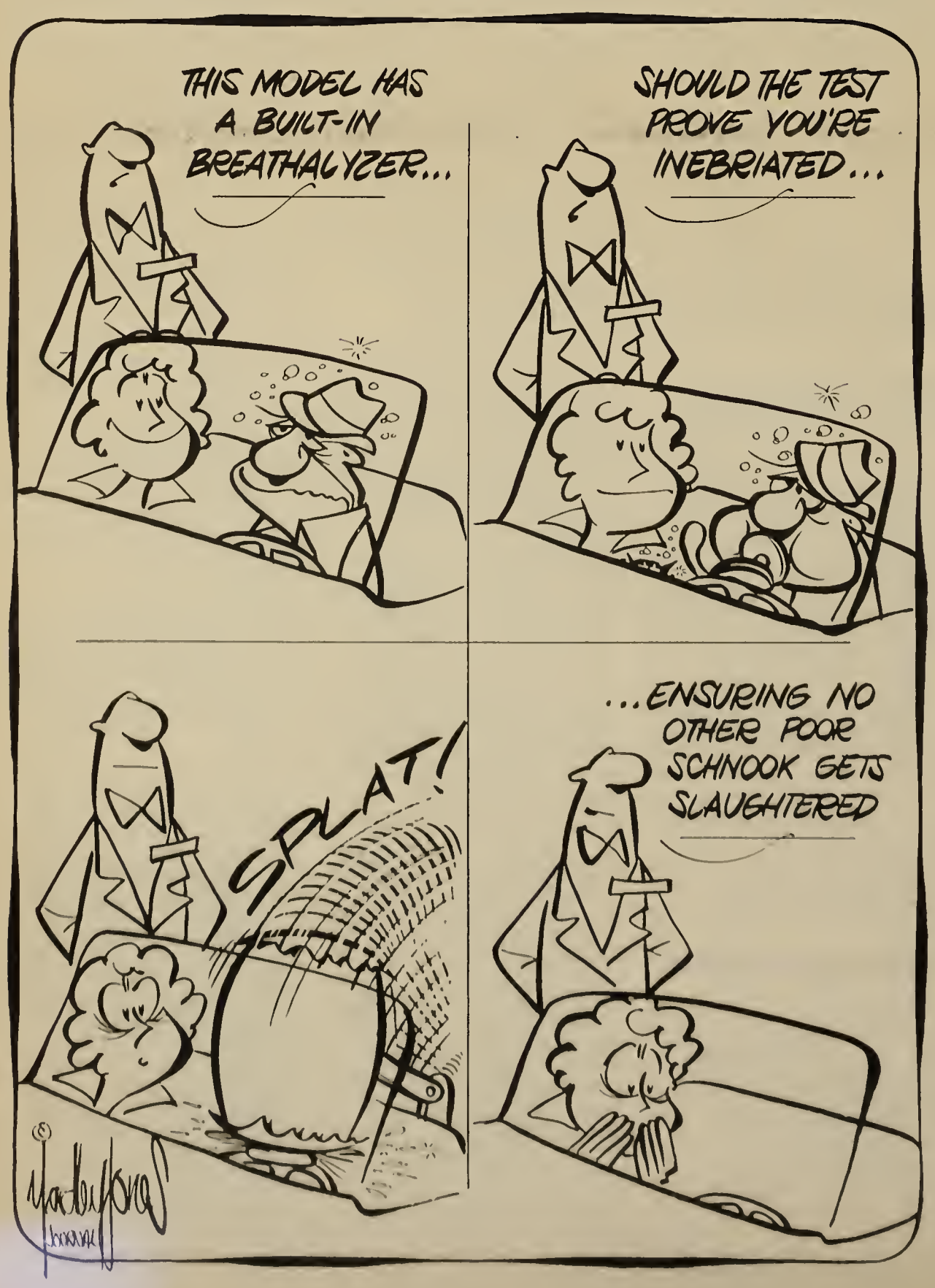
A large proportion of the many hundreds of employees who use the service each year are in the bargaining unit. We communicate with management, the union, or other agencies only with the written consent of the employee.

In our experience, many employees come for counselling before performance problems begin. Many others come because of a deterioration in work satisfaction or performance.

A consultation service exists for managers and supervisors who request assistance in managing work performance problems, or in planning for an employee's successful return to work after illness or treatment.

The success of the Employee Advisory Service has been based on the satisfaction of its clients. Ontario public servants now will have the option of choosing between two programs of assistance.

Jo Anne Greenham
Supervisor, Counselling
Employee Advisory Services
Ministry of Government Service
Toronto



DuPont's pot predictions ignoring citizens' rights

I am writing concerning Dr Robert DuPont's prediction that urine testing will soon become widespread in the United States (**The Journal**, July). His view that such testing does not violate individual civil liberties, and that this abhorrent invasion of privacy will be passively accepted by the citizens of our country, shows Dr DuPont's lack of knowledge of the past histories of failure of the moral/legal model approach to drug problems, and his lack of understanding of the rights of citizens living in a free society.


DuPont: Misguided beliefs.

If Dr DuPont believes free men will drop their pants at the whim of industry or government without a fight, he is, to say the least, misguided. However, his history of moving to the left, right, up, or down, depending on his perception of which way the wind is blowing, leads me to believe he is neither lacking in knowledge nor misguided.

It is obvious from Dr DuPont's statements he desires to be in the good graces of and serve "those in power." The problem is he obviously perceives "those in power" to be housed in Washington, DC, a state capital, or a corporate office. If he ever understands that in the US "those in power" are the citizens of this free society concerned about civil liberties, he will strive to be the president of the Civil Liberties Union rather than guru of the American Council on Marijuana.

Robert Edward Phillips
Alexis, NC

Kids and Teachers help

I would like to congratulate you on the *Kids and Teachers* supplements, (**The Journal**, Oct 1981-March 1982). I am enrolled in the York University Education program, studying to become a junior-intermediate teacher. I know a lot of students use drugs, (alcohol is included) but what shocked me, was the misinformation the students have about them.

After reading the *Kids and Teachers* supplements, I was so pleased, I passed a few copies to the teachers in my practicum school, and to some of my peers in the education program. I got feedback from them about the ideas in the section on how to inform students about drugs. They are also impressed by the way the students relate to the peer contribution in the section.

I hope this supplement of **The Journal** continues; it is giving many teachers good ideas on how to teach students about drugs, and even more importantly, it is informing students about this subject.

Kevin Kassirer
Toronto

Coverage helpful

Thank you for your excellent coverage of the recent Cocaine Today conference. (**The Journal**, July, Aug).

The information mentioned in Harvey McConnell's articles will prove very helpful in our work in Charlotte.

Stephen H. Newman, EdD
Executive Director
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FEATURE

Singapore's compulsory treatment gains ground on heroin problem

By Pat McCarthy

SINGAPORE — Tough situations, it is said, demand tough remedies. By applying this attitude to enforcement, treatment, and rehabilitation, this city state appears to be gaining ground against heroin.

More than 50% of drug abusers who undergo a rigorous compulsory program remain drug-free two years later — and the Central Narcotics Bureau claims the overall addict population has decreased by 32% during the past three years.

Vulnerable

Only 2,200 km from Asia's infamous Golden Triangle, Singapore is vulnerable to the influx of opiates. Beginning with a few cases in 1972, heroin arrests soared to 5,600 a year (87% of all drug arrests) by 1976.

The immediate concern was economic. Only 42 km long and 23 km wide, the island of Singapore has virtually no natural resources. Its primary resource is the productivity of its workers.

Because most abusers were males aged 16 to 24 years — the age group most in demand in the labor force — the heroin epidemic, in the words of the bureau's deputy director, Lohman Yew, "threatened the very core of Singapore's existence."

Fast arrests

In response, Operation Ferret was launched in 1977 "to eradicate the demand for heroin by arresting the consumers faster than there are new converts . . ."

Police, a part-time special constabulary (national servicemen on police enforcement duties in lieu of military service), and the bureau combine to detect heroin abusers and commit them to rehabilitation centres on the basis of positive urine specimens rather than court proceedings.

Says Mr Yew, it is the provision of executive power — permitting the bureau's director to order compulsory treatment and rehabilitation — that has contributed most to the success of Operation Ferret. Bypassing the time-consuming judicial process, he says, enables prompt referral for treatment and the drug user avoids the stigma of a criminal record.

Death penalties

Such an order results in an average of 12 months in one of four rehabilitation centres, followed by two years of compulsory supervision and after-care. At June 30 there were 2,886 males and 132 females undergoing rehabilitation.

Addicts who are traffickers or pushers, however, are prosecuted (penalties include death for major trafficking) and those imprisoned have a separate rehabilitation program.

A "soft" approach to treatment and rehabilitation, using replacement therapy and a daily routine Mr Yew describes as "not unlike that of a holiday camp," was abandoned in 1976. Now "cold-turkey" detoxification (except in cases of medical necessity or where the addict is aged over 55 years) takes place in more spartan surroundings.

Public support for the draconian measures was won by forming a high-level advisory committee including leading citizens and senior government officials. "There is wide support for a system that emphasizes the punishing process of 'cold-turkey' withdrawal detoxification," Mr Yew says.

Seven days of mandatory detoxification, with no medication for withdrawal symptoms, are followed by a week's recuperation and reorientation — then a week of intensive indoctrination "to drive home to the inmates the evils of the drug habit, the realities of life, and the meaningful part they can play and contribution they can make in our society," he explains.

At this stage, group and individual counselling is carried out and religious counselling, which continues throughout the program, is introduced.

A period of military-type training, building up from light callisthenics to an obstacle course and jogging, is accompanied by daily flag-raising ceremonies, kit inspections, and cleaning chores.

In the final stage, inmates are employed in industrial workshops for eight hours a day.

Because initially a high proportion relapsed within 12 months of release, a day-release scheme now serves as a "halfway house." Inmates are accepted only after spending at least six months in a centre, with a record of good behavior.

Discipline

Those who are accepted work outside the day-release camp — assembling electronic parts, spray-painting vehicles, assembling furniture — and get home leave at weekends. Urine tests and thorough searches safeguard against relapses.

The atmosphere within the camp is more like that of a hostel, with what Mr Yew calls "a bare minimum of rules and regulations to ensure that trainees lead a disciplined life." Amenities include a televison lounge, a modest library, and games courts.

On release, an addict must for two years report regularly to a police station to give urine specimens — at first, every two days; then, provided he has a job, every five days. After a year, those making a "genuine attempt to reform" need report only every 15 days.

Relapse rate

Each time, two samples are taken. They are sealed in the presence of the supervisee, who drops one into a locked box destined for the Department of Scientific Services. The second bottle is dropped into a box destined for the cold room of the Urine Bank.

If the first specimen proves positive, the supervisee is recalled to treatment and rehabilitation. He may apply to have the second specimen tested, and a negative result returns him to supervision on a two-day cycle of urine tests.

Of the 12,379 addicts treated in the first five years of Operation Ferret, 11% relapsed twice and went through the program three times. Of the 12,589 placed on compulsory supervision up to April 1980, 52% successfully completed their two years without relapsing (the relapse rate is 25% lower among those who have been through the day-release scheme).

High price

Singapore's population of heroin addicts was estimated at 13,000 in 1977. "Since then," Mr Yew says, "we have been able to obtain reliable figures. The overall drug addict population of 8,821 on Jan 1, 1979, has decreased to 6,000 by March, 1982 — a decrease of 32% over a period of three years."

Furthermore, the ratio of new to old addicts arrested has dropped to 1:4 — from 2:1 — suggesting that "the infection rate has been drastically cut."

Singapore, Mr Yew adds, pays a "high price" for its treatment and rehabilitation program. The cost for financial year 1981-82 is estimated at more than $5.1 million (Cdn) compared with $1.6 for anti-drug enforcement — all to be spread over the city state's 2.5 million population.

Male inmates at work in electronic workshop within a drug rehabilitation centre.

Volunteer aftercare officers of the Singapore Anti-Narcotics Association counsel inmates.

Electronic parts are assembled by female inmates in a workshop at one drug rehabilitation centre.

Drug rehabilitation centres come equipped with gymnastic and recreation rooms.

INTERNATIONAL

NZ alcoholism diagnostic test is 97% accurate

AUCKLAND, NZ — A new alcoholism screening test developed in New Zealand has been found to identify correctly 97% of alcoholics in more than 2,000 hospital patients. Only 1.6% of non-alcoholics were falsely classified as possibly alcoholic.

When administered to 165 alcoholic patients in treatment centres, the test correctly identified all of them.

The test was developed by G.A. Elvy and J.E. Wells for the alcohol research committee of the North Canterbury Hospital Board's Working Party on Alcohol and Drug Dependence, Christchurch.

Intended specifically for the early detection of alcohol dependency among unselected hospital patients, it is adapted from the Munich Alcoholism Test (MALT) published in 1980.

Interviews with 2,163 consecutive non-pediatric general hospital admissions and 165 patients from alcoholism treatment centres provided a pool of data from which the test of 27 scoring items was developed.

The test consists of two parts — a self-report section consisting of 24 items, and (for patients aged 30 years or more) a physician's assessment section of four items relating to a physical examination and laboratory findings.

The self-report section alone "will reliably differentiate between non-alcoholics and alcoholics," say the authors.

Beginning with "When did you last drink?" (a non-scoring question) and "How much do you normally drink each week?," the 24 self-report questions include "Have you been in hospital more than once because of accidents?," "Are you preoccupied with thoughts about alcohol?," and "Have you often been told that your breath smells of alcohol?"

A score of three or four points in this section should be considered as "possibly alcoholic," and a score of five or more as "definitely alcoholic," the authors say.

These cut-off scores are raised by one point when the physician's assessment is included. The four items to be assessed by the physician are: palpable liver, Dupuytren's contractures, elevated serum-gamma-glutamyl-transpeptidase, and elevated aspartate transaminase.

The authors say the physician's assessment adds an objective element to the test but fails to discriminate reliably between non-alcoholics and alcoholics, and thus should not be used by itself.

Drugs 'threatening' European society

EEC must act soon: report

BRUSSELS — The addict has about 10 years, at most, once dependence sets in, a family doctor has told the European Community's parliamentary assembly. "Dante himself could never have imagined the hell that an addict will go through before he finally dies."

Alexander Sherlock, a British physician and member of the European Parliament, was speaking in a debate which led to a resolution seeking a community-wide campaign to counter the spread of drug addiction among vulnerable groups such as the young and the unemployed in the 10 member countries.

The public health committee of parliament has issued a report recording a disturbing increase of drug abuse and urging the European Commission — the secretariat of the Community here in Brussels — to take immediate action on two fronts.

First, it should compile more data on drug abuse and establish a specialist organization which would coordinate drug-related research now carried out separately in the member nations.

Second, it should initiate, organize, and finance a series of information and education campaigns focused specifically at the groups most at risk.

The report shows drug abuse has increased dramatically throughout the Community during the past few years. Young people are turning to an assorted mix of drugs, tranquillizers, and hallucinogens to escape a world of unpleasant realities.

It warns: "The drug phenomenon as we know it today constitutes a serious threat to European society." And it records a series of significant recent changes in drug consumption patterns.

For example, it says, "natural" drugs from Asia, Latin America, and Africa are increasingly being replaced by synthetic narcotics on the desperate black markets of the great and prosperous cities of Western Europe. But heroin abuse is also increasing.

Consumption of alcohol — which many people remain unaware is a drug — has also grown, particularly among women and young people. Some of the figures in the report illustrate the trend. In Belgium, for instance, almost 10% of all school children have experimented with drugs at least once.

In Denmark, consumption of heroin and cocaine is increasing, although use of amphetamines seems to be falling off. A survey of drug abuse in West Germany shows that as many as 20% of the population between the ages of 14 and 20 years use drugs regularly.

Drug-induced deaths are increasing in France. In Italy, drug consumption has increased by 80% among young people between 18 and 25 years within a single year.

The report concludes that the trends demand urgent and decisive action at Community level. The same point was made by speaker after speaker at the European parliamentary debate. Each described a widening tragedy fuelling concern and demand for action in many constituencies throughout the continent.

Dr Sherlock observed that, despite intense scientific research at many institutions, modern synthetic drugs can rarely cure people once they are hooked.

One side-effect of Europe's growing drug dependence, he told the assembly, is that smuggling rings "are bringing back the kind of controls at our internal frontiers which the Common Market was set up to eliminate."

ASH to ashes: 'partisan' lobby group may lose UK funding

LONDON — The modest British government contribution to offsetting the effects of tobacco promotion here seems likely to be reduced even further.

It is widely rumored that the latest casualty in the health education ranks (**The Journal**, March) will be the Royal College of Physicians-sponsored pressure group Action on Smoking and Health (ASH).

The influential medical journal *Doctor* reports that the annual government grant of £100,000 to ASH may be withdrawn following pressure from backbench by Tory MPs.

Apparently, the MPs are incensed at repeated ASH attacks on the tobacco industry, particularly over its promotion of sport. The Minister for Sport, Neil Macfarlane, for example, is reported to be particularly offended that public money is being used to undermine the sponsorship of sporting events.

The *Doctor* report also names the Prime Minister's husband Denis Thatcher as an active opponent of ASH noting that Mr Thatcher was credited with the removal of non-smoking anti-tobacco campaigner Sir George Young from the department of health and social security earlier this year. He was a junior minister.

Doctor reports an unnamed source as saying: "There is growing opposition on the Tory benches to giving taxpayers' money to a partisan organization that is endangering a useful supply of revenue to the exchequer as well as jobs and profits in the tobacco industry.

"It looks as if ASH will be leant on discreetly — or lose its grant in future. Hostile comments about Tory MPs from some ASH spokesmen are increasingly resented and now the tobacco giants are moving in for the kill. They've got the ear of several ministers and highly-placed Conservative party benefactors."

Much of the speculation about the future of ASH — regarded as a model of successful pressure groups — follows a reception in the House of Commons organized by FOREST — the Freedom Organization for the Right to Enjoy Smoking Tobacco.

Thatcher: An active opponent of ASH?

But the death blow to ASH won't be achieved without a squawk of protest. Clement Freud, Liberal MP said: "I deeply mourn the passing from the health department of Sir George Young, who did a great deal for the campaign against smoking. I think the people who are now at the department of health and social security are far more concerned with raising revenue from tobacco than with any other aspect of smoking."

The MP added he would be strongly opposed to any attempt to cut the ASH grant.

After 10-year lull

Hong Kong sees sharp increase in heroin abuse

By Lachlan MacQuarrie

HONG KONG — The number of young heroin addicts here has risen sharply after more than 10 years of progressively-declining drug abuse by youth, says Peter Lee, Hong Kong's commissioner for narcotics.

Mr Lee told a recent anti-narcotics seminar for school administrators they must mobilize all possible resources to warn the young of the dangers of drug addiction.

He said that in 1981 the number of people between 15 and 19 years old first reported to Hong Kong's Central Registry of Drug Addicts (CRDA) was 571 — more than double the number in the previous year.

Mr Lee said also that there is a growing trend for traffickers to use young people as couriers: "The number of young people charged with minor, drug-related offences has increased 37%."

In recent years, Hong Kong's drug fighters had been encouraged by the steady and substantial decrease in the incidence of addiction among the young. In the 10 years from 1969 to 1979, the proportion of people under age 21 treated in the voluntary patient program of the Society for the Aid and Rehabilitation of Drug Abusers (SARDA) had shown a steady decrease to 2.9% from 15.4% of the total patients treated. Similarly, the proportion of young addicts in the Hong Kong Prisons department's compulsory treatment program had dropped during the same period to 3.7% from 25%.

The sudden rise in heroin abuse among the young has been attributed by some here to the bumper opium harvest of 1980/81 in the growing areas of Burma, Laos, and Thailand (the 'Golden Triangle'), and the resulting decline in the Hong Kong street price of heroin.

However, James Ch'ien, superintendent of social service for the SARDA, believes this is an oversimplification.

He told the school administrators' seminar that, "it takes an average of three years between the onset of drug abuse and the time of the first report for treatment." Thus, he said the better-than-average opium harvest in the Golden Triangle, and the resulting fall in heroin prices, are not likely to have been major factors because they are too recent.

Mr Ch'ien reported also that the SARDA's experience during the past two years bears out the central registry's statistics on increasing heroin abuse among the young. He said that in 1980 there were 23 people under the age of 19 treated by the SARDA. For 1982, this had risen to 55.

Mr Ch'ien also said that the proportion of first admissions to the SARDA as compared with total admissions (including second and subsequent admissions) was substantially higher in the teenage group. First-time admissions constituted 24% of admissions for all ages while first-timers in their teens were 71% of total teenage admissions.

Lee: Mobilize all resources.

"This proportionately much higher, first-time admission rate among teenagers reflects a rising incidence of young persons beginning to use drugs in the past few years, especially in view of the three-year average gap between first experimentation with heroin and eventually seeking treatment," Mr Ch'ien said.

Thousands of anti-drug pamphlets are issued each year for Hong Kong youth.

Junior high students seen as vulnerable

HONG KONG — Today's young addict here has a higher level of education, a higher level of family income, and is more likely to have been born in Hong Kong than would have been the case in previous years, according to statistics from the SARDA (Society for the Aid and Rehabilitation of Drug Abusers).

Ninety-seven per cent of teenage addicts treated this year were born in Hong Kong, says SARDA's superintendent of social service James Ch'ien.

"We have a situation involving imported drugs but locally-produced users," said Mr Ch'ien, "and these developments have taken place in a period when, according to figures issued by Hong Kong's Census and Statistics department, the proportion of young persons in the population has actually declined slightly.

"The fact that the overwhelming majority of the teenage male addicts and all the females studied were born in Hong Kong, and came generally from families with modest incomes, indicates the problem is locally produced and not necessarily linked with poverty.

"The crowded living environments where most of our patients reside could be an indirect cause, as could the lack of wholesome recreational activities, and the strained family relationships which we found," Mr Ch'ien said.

He recommended that Hong Kong's junior high school students should be viewed as a high-risk group and receive special attention in both primary and secondary prevention, with particular emphasis on recreation and sports services, volunteer service activities, crisis intervention, and other outreach social programs.

Drinkers signing 'sick' notes has UK docs reconsidering

LONDON — The British medical profession has campaigned for 20 years for the introduction of "self-certification" for short illnesses.

But with the introduction of a scheme allowing employees to sign their own sick notes for illnesses of up to one week's duration, the profession appears to be having second thoughts.

Notable among the protestors is Hugh Gough-Thomas, executive director of this country's Medical Council on Alcoholism.

He pointed out that the self-certification scheme, promoted by the British Medical Profession to cut out "unnecessary" paper work by family physicians, could have the effect of "sweeping one of Britain's biggest problems under the carpet."

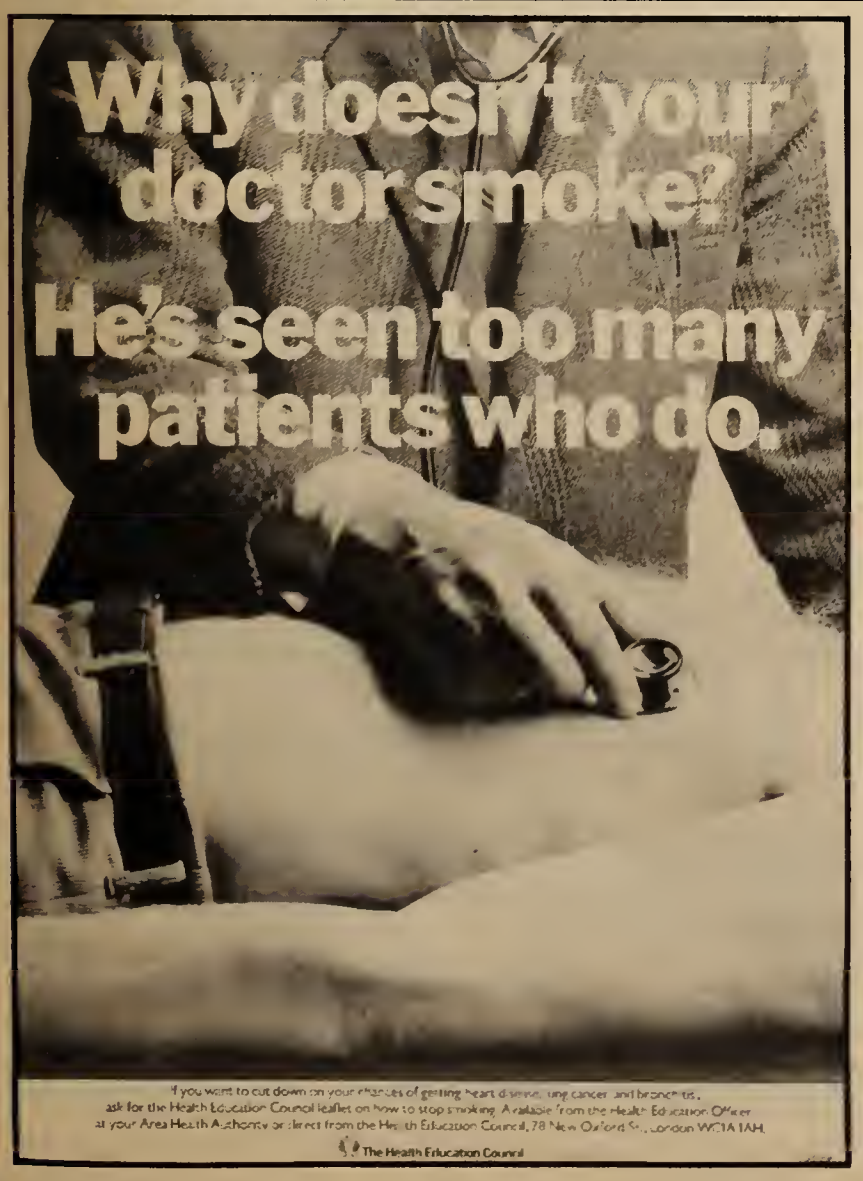
Dr Gough-Thomas was, of course, referring to alcoholism.

"Problem drinkers need to be detected as quickly as possible, and this is best done by a general practitioner (family physician) alert to the meaning of a patient complaining of diarrhea and headaches," he said.

"But with self-certification, these people will not have to visit a doctor if they want to take time off, so they will go undetected."

Dr Gough-Thomas's response to the problem is to suggest urgent talks with the Royal College of General Practitioners. "What we need to do is to set up tests in around six industrial practices to see what effect self-certification is having on absenteeism and the diagnosis of alcoholism," he said.

Dr Gough-Thomas has been supported by Dr Peter Chivers, consultant occupational health physician to a major brewery. He said that industrialists were more and more conscious of the need to keep workers in their place of work and working. Computers would be used to monitor their performance and Monday morning absenteeism would soon be picked up.



UK public now links smoking/heart disease following HEC drive

LONDON — The British public is finally catching on that smoking is linked with heart disease.

The good news for doctors comes from the British government-sponsored Health Education Council (HEC). The council organized a public opinion survey in February which found that 45% of a sample recognized the association, compared to only 36% in a similar survey in 1981.

When asked to suggest ways of preventing heart attacks, 39% said people should give up, or cut down on smoking compared to 28% in the first survey.

Between the two surveys, the HEC had mounted a television advertising campaign warning that smokers risk heart disease.

The latest poll also discovered the public still believes stress is a major cause of heart disease — although medical opinion is divided on the importance of stress — and that overweight, lack of exercise, and an unhealthy diet are also blamed.

The director designate of the HEC, Dr Keith Taylor, said: "We are pleased that the public is increasingly making the connection between smoking and heart disease. The more people are aware of the risks attached to various forms of behavior, the better are the chances of reducing the toll of heart disease, which accounts for more than a quarter of all deaths in Britain."

The HEC has endorsed a five-point plan for heart disease prevention proposed by the department of health and social services: don't smoke; follow your doctor's advice on raised blood pressure; maintain ideal weight; control the amount of fat in your diet, and find an enjoyable method of relaxation, preferably involving exercise.

Promotional campaigns get good results for the HEC.

NEWS

Drug research is muddied by sundry dependence concepts

MONTREAL — It's unusual to hear a pharmacologist apologize for the role of pharmacology in drug research.

Nevertheless, Harold Kalant of the Addiction Research Foundation, Toronto, says "pharmacology has tended to muddy the waters with respect to the concept of drug dependence.

"I'll apologize for the role of pharmacology," he told the annual meeting of the Canadian Psychological Association here.

Dr Kalant took issue with the World Health Organization (WHO), a body which he said "is very much involved with the problems of drug dependence." Over the years, the WHO has issued definitions of drug dependence, all based on the concept of drug dependence as a state of chronic exposure of an organism to a drug. However, the WHO ignored the most fundamental question — why a person having experienced the effects of a drug, would want to go back again and again to reproduce that chronic state.

"Fortunately, the WHO has modified its position. The most recent version does not talk about exposure to a drug, but about interaction between the drug and the individual. That's an improvement. At least they recognize there is an individual there."

Dr Kalant further criticized excess preoccupation with pharmacological aspects in the current debate on the role of receptor changes in the production of drug dependence.

"Unlike the classic view of drug dependence as a state produced by the drug, I would like to present the concept that it is not a state, but a behavior. Further, it is not determined by the drug itself but by the interaction of the drug, the subject, the previous history of the subject with respect to drug effects and other influences, and current environmental contingencies at the time the drug is taken."

Dr Kalant said he would prefer to avoid the use of the word "dependence" (other than in a limited sense). In the case of ethanol, for example, on first ingestion, the drug produces identifiable acute effects. These acute effects for alcohol (or for any other psychoactive drug) can be classified as aversive effects and positively reinforcing effects.

Dr Kalant said that aversive effects are those which tend to minimize the likelihood that the drug experience would be repeated. On the other hand, reinforcing effects are of several types — and might simply be social reinforcement. Thus, the balance between aversive and reinforcing effects will determine the probability of repeated exposures.

About tolerance Dr Kalant said the striking thing is that tolerance is demonstrable principally (if not exclusively) in terms of aversive effects.

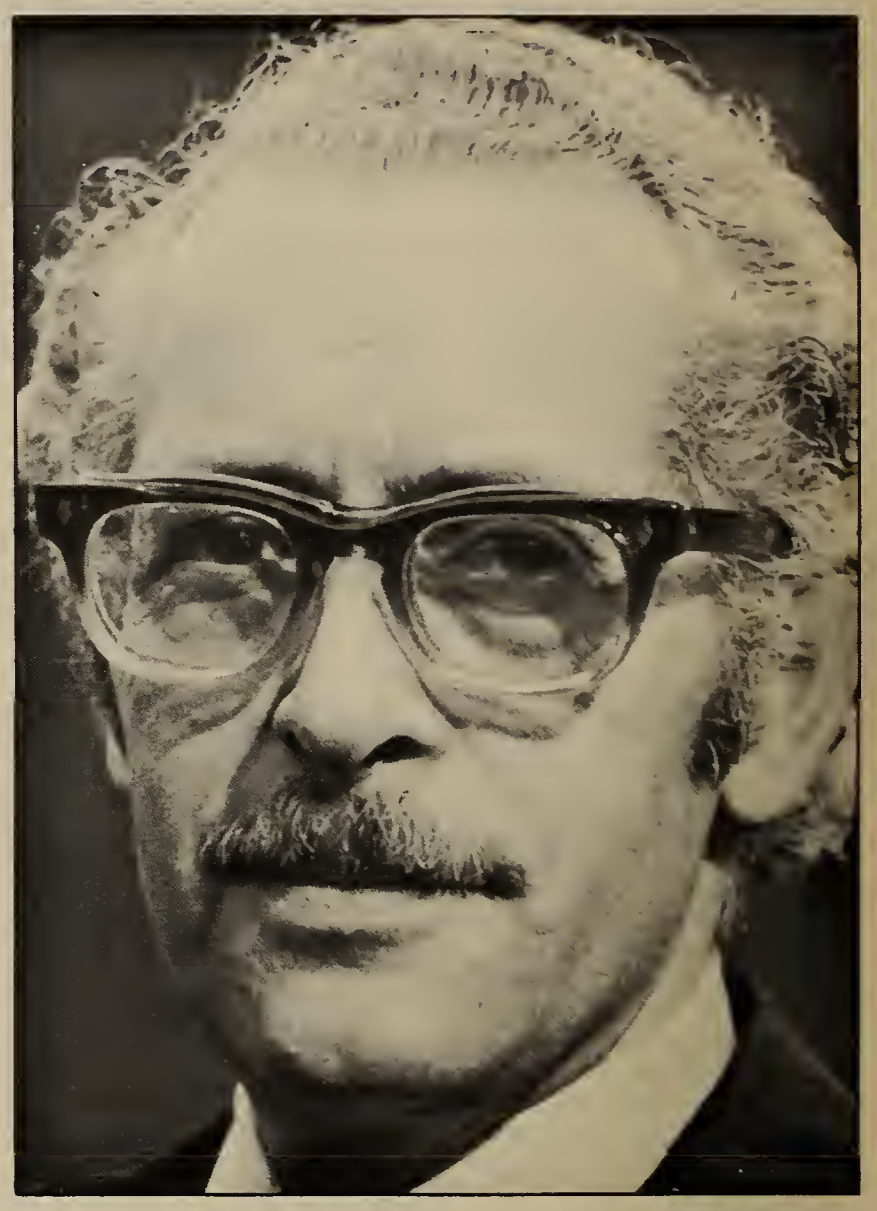
However, if the aversive effects lessen, "allowing the individual to enjoy the reinforcing effects more intensely, the likelihood of repetition and the strengthening of self-administration behavior increases."

Physical dependence generally accompanies tolerance, Dr Kalant said. "I believe they are two manifestations of the same phenomenon, a biologically adaptive phenomenon which occurs in all living organisms and in many types of stimuli, not just drug stimulus."

Regarding cross-tolerance, Dr Kalant said: "There is cross-tolerance and specific conditions for specific effects between alcohol, which does not have specific receptors, and opiates which do. How do you explain that in pharmacological terms?" Further research is needed on this and on relating physical dependence to the mechanism of reinforcement.

Dr Kalant said that drug dependence and its respective elements have to be explained at two different levels — pharmacological and behavioral.

"These are parallel levels of explanation, not hierarchal," Dr Kalant concluded. "You cannot explain everything with one or the other. You have to use both. The types of investigation done in terms of behavior and pharmacological effects will not aid our understanding unless they deal with interaction of the drug organism and behavioral circumstances."



Kalant: Drug dependence a behavior — not a state.

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Battered Wives

Number: 511.
Subject Heading: Alcohol and the family, attitudes, professional training.
Details: 45 min, 16mm, color.
Synopsis: This drama focuses on wife abuse in two families. The husband in one family beats his wife when he is drunk; the other husband abuses his wife when under stress. Both wives seek advice from friends but they only say that "married couples have their differences." Finally, the women decide to take their children and leave. They find refuge in a women's shelter where they regain some self-esteem and begin to restructure their lives. When the alcoholic husband joins AA (Alcoholics Anonymous) his wife agrees to attempt a reconciliation.
General Evaluation: Very good. This emotionally-charged, realistic, and informative film was judged to be an effective teaching aid. Public broadcast was recommended.
Recommended Use: Of benefit to adult audiences especially drug abusers, health professionals, and abused women.

AA and the Alcoholic

Number: 512.
Subject Heading: Alcohol and alcoholism overview, alcohol and the family, treatment.
Details: 44 min, 16mm, color.
Synopsis: This film looks at popular myths surrounding Alcoholics Anonymous (AA) by examining questions surrounding the history, development, and philosophy of the organization. It explains that AA "does not protect people from the consequences of their own actions," but tries to help people who *want* to stop drinking.
General Evaluation: Fair. Although this is a contemporary, information-filled film, because of its length it was judged to be boring.
Recommended Use: Could be useful to alcohol abusers, and health professionals.

Our Children Are Our Future

Number: 509.
Subject Heading: Native people.
Details: 51 min, 16mm, color.
Synopsis: Many native children are in the care of child welfare agencies. Some are placed in non-native foster homes; others in native homes. Interviews with native court counsellors and Indians themselves, uncover some of the problems these children and their foster parents face.
General Evaluation: Very good to excellent. This contemporary, realistic, and informative film was judged to be an effective teaching aid in its presentation of native people's issues. General broadcast was recommended.
Recommended Use: This film is likely to benefit native groups and those working with native people.

Family Trap

Number: 508.
Subject Heading: Alcohol and the family, professional training.
Details: 30 min, 16mm, color.
Synopsis: Utilizing "Systems Theory," this film examines the effect of one "chemically dependent person" on other members of the family. Emotional investment binds the family together and a chemically-dependent person can put too much stress on the system, thereby making it not function effectively.
General Evaluation: Fair. In spite of the group's reservations regarding the systems theory model, it is informative and could be helpful for families with a chemically-dependent member.
Recommended Use: Adults, families, with drug-related problems and health professionals, provided a resource person is present to discuss the issues raised.

This publication is indexed in

BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

DEPARTMENT

New Books

by RON HALL

Estimating The Number Of Alcoholics In Ontario

An Analysis by County

. . . by Brian Rush, Scott Macdonald, and Norman Giesbrecht

This working paper provides updated statistics for 1979 on the estimated prevalence of alcoholism in Ontario. Prevalence estimates based on alcohol sales data are presented for each Ontario county, then aggregated to the regional and provincial level. For the year 1976, comparisons are made among prevalence rates obtained from alcohol sales data and alternative procedures based on alcohol-related mortality (cirrhosis, alcoholism, and suicide). The data support previous findings which show the highest prevalence rates in Northern Ontario and the major urbanized centres in the South. Comparisons of the alternative estimation procedure at the regional level showed that the rates obtained by the alcohol consumption method were the most conservative and the most consistent over time. Regional rates based on alcoholism mortality are subject to the most temporal fluctuation. County variation within regions of the province was highest in the North, and the East, and lowest in the West.

(Addiction Research Foundation, Marketing Services, 33 Russell Street, Toronto, Ontario M5S 2S1, 1982. 55p. $5.95. ISBN 0-88868-063-5 ISSN 0708-5133)

Drinking and Damage: Theoretical Advances and Implications for Prevention

. . . by B. Gail Frankel and Paul C. Whitehead

The authors indicate that there have been two major explanations for differing levels of alcohol-related damage in society with different recommendations for public policy. The sociocultural model holds that where there are clear norms governing alcohol use, where alcohol use is settled and socially intergrated, where harmful use is quickly prescribed, and where the young learn these rules at an early age, low rates of alcohol-related damage are likely to result. The second; the distribution-of-consumption model is that the level of many alcohol problems in a society is significantly related to the level of per capita consumption in the society, and that lowering or limiting increases in per capita consumption is a vital public health goal. As important, this thesis holds that alcohol consumption is structured or distributed in fairly-predictable patterns in the industrialized societies, with changes in this structure occurring in fairly-predictable ways. The authors explore the strengths and weaknesses of these models of alcohol use and alcohol-related damage, and present a new model — a synthesis of the two. The three models are tested with path analysis, using cross-cultural data on 68 societies. The implications of the results for the prevention of alcohol-related problems are discussed.

(Rutgers Center of Alcohol Studies, New Brunswick, NJ, 1981. 99p. ISBN 911290-095)

Directory Of Alcohol And Drug Treatment Resources In Ontario 1982

. . . edited by Catherine Blake

An update of a previous directory, this work lists addiction-specific and general resources throughout Ontario. A resource is defined as an organization that provides service to clients, either as an autonomous facility itself, or as a program within a larger organization. An addiction-specific resource is identified as having a major goal of altering the chemical dependency pattern of its clients, and usually having at least 50% of its caseload presenting with alcohol or other drug problems. General health, social, and correctional resources are included if they have a significant interaction (10% to 20% of annual caseload) with substance-abusing clients. Each addiction-specific program has been described independently whether or not it is part of a larger organization. The description includes: agency name, address, director's name, area served, description of services, substances, client types, intake policy, waiting period, services offered, number of beds, cost, average length of stay, and business hours. The directory is arranged geographically and includes an index.

(Addiction Research Foundation, Marketing Services, 33 Russell Street, Toronto, Ontario M5S 2S1, 1982. 383p. $29.95. ISBN 0-88868-070-8, ISSN 0228-863X)

Other Books

Frontiers In Liver Disease — Berk, Paul D., and Chalmers, Thomas C. (eds). Thieme-Stratton Inc, New York, 1981. Bile formation and metabolism; fibrosis and regeneration; toxicology; diagnosis and pathology; alcohol and the liver; hepatitis viruses; primary biliary cirrhosis; hepatic cancer. Index. 347p. $42.

Substance Abuse: Clinical Problems and Perspectives — Lowinson, Joyce H., and Ruiz, Pedro (eds). Williams and Wilkins, Baltimore, 1981. Theories of substance abuse; substances of abuse; treatment approaches; techniques of intervention; special treatment problems; target groups; evaluation; training. Index. 885p. $77.55.

Police Referral to Drug Treatment: Risks and Benefits — Bellassai, John P. Maloney, Mary Ann, and Johnson, Jr, Ford T. US Government Printing Office, Washington, 1981. Program typologies and salient issues; description and analysis of pre-charge program operations in six cities; findings and recommendations. Bibliography. 91p.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:
a) Regular Line Rates — $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) — $1,000
½ Page (560) lines) — $500
¼ Page (280 lines) — $250
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Circulation: 15,094

(Ontario, 11,580; other provinces, 815, USA, 1,979; foreign, 720). Bulk, 3,700, Media, 1,273

Single Subscription Rates:
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Other Canadian Residents $12 per year
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ISSN 0044-6203 Printed in Canada

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Workshop on Evaluation Research in the Field of Addictions — Sept 8-9, Regina, Saskatchewan. Information: Brian Rush, Addiction Research Foundation, Research Centre for Regional Programs, University of Western Ontario, London, Ontario N6A 3K7.

Canadian Medical Association Annual Meeting — Sept 20-24, Saskatoon, Saskatchewan. Information: CME Office, University of Saskatchewan, 408 Ellis Hall, Saskatoon, SK S7N 0W0.

Early Recognition and Management of Health Problems in the Workplace — Sept 27, Oct 28, Nov 25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Detox Training Programs (Non-Medical) — Sept 27-Oct 1, Oct 25-29, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Canadian Psychiatric Association 32nd Annual Meeting — Sept 29-Oct 1, Montreal, Quebec. Information: Lea Metivier, Chief Administrative Officer, Canadian Psychiatric Association, Suite 103, 225 Lisgar, Ottawa, Ontario K2P 0C6.

The Canadian Group Psychotherapy Association 3rd Annual Conference — Oct 2-4, Montreal, Quebec. Information: Allen A. Surkis, Room 677, Montreal General Hospital, 1650 Cedar Ave, Montreal, PQ H3G 1A4.

Canada Safety Council — Oct 3-4, Calgary, Alberta. Information: CSC, 1765 St Laurent Blvd, Ottawa, Ontario K1G 3V4.

American Association for Automotive Medicine — Oct 4-6, Ottawa, Ontario. Information: AAAM Secretariat, PO Box 222, Morton Grove, Illinois 60053.

Librarians and Information Specialists in Addictions — Oct 5-8, Ottawa, Ontario. Information: Betty Garland, Librarian, Health Services and Promotion Branch, Room 500, Jeanne Mance Building, Ottawa, ON K1A 1B4.

The National Conference of the Canadian Mental Health Association — Oct 6-9, Victoria, BC. Information: J. Terry Gordon, Assistant Executive Director, CMHA, (BC Division), 692 E 26th Ave, Vancouver, BC V5V 2H7.

American College of Chest Physicians — Oct 10-15, Toronto, Ontario. Information: A. Soffer, MD, FCCP, 911 Busse Highway, Park Ridge, Illinois 60068.

American Society of Criminology — Nov 4-6, Toronto, Ontario. Information: Harvey C. Horowitz and Associates, 10369 Currycomb Crt, Columbia, Maryland 21044.

110th American Public Health Association Annual Meeting — Nov 14-18, Montreal, Quebec. Information: Sam Lomauro, Conventions and Exhibits Manager, American Public Health Association, 1015 15th St NW, Washington, DC 20005.

The Management of Employee Assistance Programs — Feb 23-25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

25th Annual Scientific Assembly of the College of Family Physicians of Canada — Apr 24-27, 1983, Toronto, Ontario. Information: George Ackehurst, Director of Communications, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, Ontario M2K 2R9.

Medic Canada '83 . . . Toward the Year 2000 — May 29-31, 1983, Edmonton Alberta. Information: Toby Fay Sykes, Medic Canada '83, 480 Garyray Dr, Toronto, Ontario M9L 1P8.

Fifth World Conference on Smoking and Health — July 10-15, 1983, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, Ontario K1A 0C1.

United States

An Integrated Management System for Administrators in Alcoholism — Sept 9-10, Chicago, Illinois, Oct 13-14, Phoenix, Arizona. Information: Kim Hilberg, Program Coordinator, NAATP, 1300 Bristol St N, Newport Beach, California 92660.

Evaluating Alcohol and Drug Programs: Current Methods and Findings — Sept 13-17, Brooklyn Park, Minnesota. Information: Leslie Nyberg, Evaluation and Research department, Box 11, Center City, Minnesota 55012.

Training School on Alcohol and Drug Abuse — Sept 13-30, Minneapolis, Minnesota. Information: Betty Reynolds, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441.

2nd Annual Workshop on Marketing Mental Health and EAP Services — Sept 15-18, Snowmass-Aspen, Colorado. Information: Sara Bilik, Colorado West Regional MH Center, PO Box 1580, Glenwood Springs, CO 81602.

Intimacy and Sexuality Issues — Sept 17-18, Milwaukee, Wisconsin. Information: Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Alcoholism Treatment: Cooperation or Competition — Sept 20-22, La Jolla, California: Information: Naomi Feldman, Conference Coordinator, 3770 Tansy, San Diego, CA 92121.

Intervention Skill Building Workshop — Sept 20-24, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441.

5th National Impaired Physician's Conference — Sept 22-25, Portland, Oregon. Information: AMA, Department of Mental Health, 535 N Dearborn, Chicago, Illinois 60610.

The 5th Annual Current Concerns in Adolescent Medicine — Sept 23-24, New York, NY. Information: Ann Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Introduction to Counselling — Sept 27-28, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

American Neurological Association 107th Annual Meeting — Sept 30-Oct 2, Washington, DC. Information: John Conomy, MD, Chairman, Press and Public Relations, American Neurological Association, The Cleveland Clinic Foundation, 9500 Euclid Ave, Cleveland, Ohio 44106.

The Master of Science in Management (MSM) — October, Cambridge, Massachusetts. Information: Management Division, Lesley College Graduate School, 1627 Massachusetts Ave, Cambridge, MA 02138.

Workshop on Chemical Dependency and Adolescents — Oct 3-8, Minneapolis, Minnesota. Information: Maryann Pennington, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441.

American Academy of Family Physicians — Oct 4-7, San Francisco, California. Information: R. Tusken, 1740 W 92nd St, Kansas City, Missouri 64114.

Advanced Counselling Skills — Oct 6-Nov 10, Milwaukee, Wisconsin. Information: Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Women, Alcohol, Drugs, and Sexuality — Oct 8-9, Milwaukee, Wisconsin. Information: Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

The Benzodiazepines Today: Two Decades of Research and Clinical Experience — Oct 8-11, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, CA 94117.

15th Annual MAAA Fall Conference and 2nd Annual Medical Conference — Addictions: Awareness, Assessment, and Action — Oct 10-13, Harbor Springs, Michigan. Information: Sally J. Myers, Administrative Assistant, MAAA, 29563 Northwestern Highway, Suite 7, Bldg F, Southfield, MI 48034.

6th Annual Drug and Alcohol Abuse Conference — Oct 12-14, Lancaster, Pennsylvania. Information: Carol A. Williams, Chief, Division of Intervention Services, Office of Drug and Alcohol Programs, 2010 N Front St, Building #3, Harrisburg, PA 17120.

Family Systems Theory Workshop — Oct 14-15, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441.

Conference on Alcoholism Treatment Evaluation: Issues and Applications — Oct 14-15, Fort Worth, Texas. Information: Wendy Lipton, Center for Organizational Research and Evaluation Studies, Texas Christian University, PO Box 32874, Forth Worth, TX 76129.

Advanced Counselling Skills — Oct 15-16 and 29-30, Milwaukee, Wisconsin. Information: Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

A Spiritual and Communal Gathering — A Jewish Retreat Weekend for Recovering Alcoholics, Chemically Dependent Persons and Significant Others — Oct 15-17, Woodbourne, New York. Information: Sheldon Baron, Registrar, Retreat Weekend, JACS Foundation, Inc, NY Board of Rabbis, 10 E 73rd St, NY, NY 10021.

Basic Workshop on Chemical Dependency and the Family — Oct 18-22, Minneapolis, Minnesota. Information: Maryann Pennington, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441.

National Safety Council — Oct 19-22, Chicago, Illinois. Information: NSC Congress Planning Department, 444 Michigan Ave, Chicago, IL 60611.

Directions in Alcohol Abuse Treatment Research — Oct 20-23, Newport, Rhode Island. Information: Barbara S. McCrady, Butler Hospital, 345 Blackstone Blvd, Providence, RI 02906.

National Black Alcoholism Council Inc, 4th Annual National Conference — Oct 21-24, San Diego, California. Information: Don Owens, NBAC National Conference Planning Committee, 4208 National Ave, San Diego, CA 92113.

Sleep Disorders In Children: SIDS — Sleep Apnea Research and Evaluation — Oct 22, New Hyde Park, New York. Information: Ann J. Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Human Sexuality and Chemical Use — Oct 25-29, Minneapolis, Minnesota. Information: Betty Reynolds, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441

Impact: Adolescent Chemical Dependency: A School Program — Oct 25-29, Nov 15-19, Orange County, southern California. Information: Tim Allen, manager of Educational Services, Problem Talk Shop, 2101 E 4th St, Suite 185, Santa Ana, CA 92705.

Annual Postgraduate Course in Clinical Pharmacology, Drug Development and Regulation: 1982 — Oct 25-29, Rochester, New York. Information: William M. Wardell, The University of Rochester Medical Center, Department of Pharmacology and Toxicology, 601 Elmwood Ave, Rochester, NY 14642.

3rd Annual Seminar, Alcoholism in the Black Community — Oct 30, Newark, New Jersey. Information: ABC, c/o RAFT, East Orange General Hospital, 300 Central Ave, East Orange, NJ 07019.

Association for the Advancement of Psychotherapy — Oct 31, New York, New York. Information: S. Leese, MD, 114 E 78th St, NY, NY 10021.

American Association for the Study of Liver — Oct 31-Nov 3, Chicago, Illinois. Information: M. Sorrell, MD, Department of Internal Medicine, University of Nebraska Medical Center, 42nd and Dewey Ave, Omaha, Nebraska 68105.

Sexuality and Alcohol/Drug Dependence — Nov 1-2, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

11th Annual Meeting of the Association of Labor Management Administrators and Consultants on Alcoholism (ALMACA) — Nov 2-5, Philadelphia, Pennsylvania. Information: ALMACA, 1800 N Kent St, Suite 907, Arlington, Virginia 22209.

Alcohol, Drugs, and Aging: Development, Diagnosis, Treatment — Nov 8-9, Coatesville, Pennsylvania. Information: Dr K. A. Druley, Chief, SATU (116A5), CVAMC, Coatesville, PA 19320.

Women In Crisis Inc, Fourth Annual Conference — Nov 10-13, New York, NY. Information: Women In Crisis Inc, 37 Union Square W, NY, NY 10001.

An International Perspective on Substance Abuse: The Problem, Its Treatment, and Medical Education — Nov 15-19, Oakland, California. Information: Dr Charles Buchwald, Conference Coordinator, Downstate Medical Center, 450 Clarkson Ave — Box 129, Brooklyn, New York 11203.

Clinical Decision Making in Alcoholism and Drug Abuse — Dec 6-10, New York, NY. Information: Andrew J. Gordon, Smithers Alcoholism Treatment and Training Center, St Luke's-Roosevelt Hospital Center, 428 West 59th St, NY, NY 10019.

Abroad

33rd International Congress on Alcoholism and Drug Dependence — Oct 9-15, 1982, Tangier, Morocco. Information: Archer Tongue, International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

International Workshop on Drug Education — Nov 23-26, Dublin, Ireland. Information: Education and Training Division, Health Education Bureau, 34 Upper Mount St, Dublin 2, Ireland.

International Conference on KHAT — The Health and Socio-Economic Aspects of KHAT Use — Jan 17-21, 1983 Antananarivo, Madagascar. Information: Archer Tongue, Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

NSAD 10th Biennial Summer School on Alcohol, Drugs and Chemical Dependency — Jan 26-28, 1983, Wellington, New Zealand. Information: Bursar, Barbara Mills, NSAD, PO Box 1642, Wellington, New Zealand.

7th World Congress of Psychiatry — July 11-16, 1983, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, 1983, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, 1983, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, 1983, Tel Aviv, Israel. Information: Judge Amnon Carmi, Chairman, Organizing Committee, 2nd International Congress on Drugs and Alcohol, PO Box 394, Tel Aviv 61003, Israel.

PART ONE

Drugs, alcohol, and the Charter

The April 17th proclamation of Constitution Act, 1982 has been heralded as representing Canada's coming of constitutional age. Now, like the United States and almost every other "modern" nation, Canada has a written constitution in which specific rights and freedoms are formally guaranteed and ascribed a legal status paramount to any ordinary legislation.

It is too soon to predict whether the "Canadian Charter of Rights and Freedoms" (or "the Charter," as it has become known) will have a profound effect on the lives of Canadians or whether it will prove little more than a constitutional centerpiece. What is certain, however, is that the next five to 10 years will prove a challenging and exciting period for the legal profession as the scope of the liberties defined in the Charter are judicially tested. Undoubtedly, one of the legal arenas most likely to experience this flurry of judicial activity is that of drug and alcohol-related offences. These areas will be specifically examined in a subsequent article but an appreciation of their significance requires a preliminary canvassing of the structure and operation of the Charter.

By Mel Green and Robert Solomon*

Canadians had rights and freedoms long before they were entrenched in a written constitution. The common law — that great accumulation of judicial precedents and wisdom — has recognized and protected a broad range of individual liberties for hundreds of years. In our political system, however, these rights and freedoms have always been subject to the doctrine of parliamentary sovereignty. As one constitutional scholar put it: Parliament has the power "to make or unmake any law whatever" — irrespective of the courts' views on the subject. The 1960 Canadian Bill of Rights represented a first, large-scale attempt to codify common law rights. However, Canadian courts reacted in a very conservative fashion, turning aside almost every challenge to prevailing legislation that was founded on a Bill of Rights guarantee. In any event, the Bill of Rights applied only to federal legislation; it did not extend to laws passed by provincial legislatures.

At least on paper, the Charter constitutes a significant advance over the Bill of Rights. The Charter has a constitutional status and applies to both federal and provincial legislation. More importantly, it clearly grants the judiciary the power to develop the rights and freedoms set out in the Charter and, where necessary, to render inoperative those laws that are inconsistent with the Constitution. Some have even suggested that this latter provision substitutes the notion of judicial supremacy for that of parliamentary sovereignty.

From a criminal lawyer's perspective, the most significant rights and freedoms are those set out in section 2 and sections 7 to 15 of the Charter.

Section 2 guarantees those "fundamental freedoms" that have become the hallmark of modern constitutional documents: freedom of conscience and religion; freedom of thought, belief, opinion, and expression, including freedom of the press; freedom of peaceful assembly; and freedom of association.

The "legal rights," listed in sections 7 through 14, include: the right to life, liberty, and security of the person; the right to be secure against unreasonable search and seizure and arbitrary detention or imprisonment; the right, on arrest, to be promptly informed of the reasons for one's arrest and that one is entitled to retain and instruct counsel without delay; the right to be tried within a reasonable time, not to be a compellable witness against oneself, and to be presumed innocent; the right to reasonable bail, not to be subject to cruel and unusual treatment or punishment; and the right to an interpreter where required.

Section 15 guarantees that everyone is equal "before and under the law" and is entitled to equal protection and benefit of the law. This section, unfortunately, does not come into effect until 1985.

Of greater concern, however, is the fact that all of these meticulously-described rights and freedoms are subject to provincial or federal overrides. In essence, any legislature can deny the operation of these rights simply by declaring that a particular piece of legislation is to operate notwithstanding any of these Charter rights and freedoms. So far, neither Parliament nor any provincial legislature has availed itself of this "notwithstanding" provision, although Quebec has indicated an intention to do so.

Section 1 of the Charter imposes an additional limitation on the scope of these rights and freedoms. It basically provides that all Charter guarantees are subject "to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

In other words, whenever an accused alleges that his guaranteed right or freedom has been infringed, the Crown (ie, the prosecutor) may well argue that any such infringement was, in effect, reasonable and justified. For example, section 10 provides that arrested people have a right to be informed promptly of the reasons for their arrest. This is hardly a new right as it has been firmly recognized by the common law for centuries; but these same courts have also ruled that where the reason for the arrest is obvious, then this common law police obligation evaporates. The section 10 right, then, is already subject to "limits prescribed by law" which the courts are likely to continue to view as "reasonable." But can these limits also be "demonstrably justified in a free and democratic society?" Here the courts will not only examine Canadian precedents but, where relevant, will look to the law in other similar jurisdictions such as the United States, the United Kingdom, Australia, New Zealand, and the European Economic Community.

A singular advantage of the new Charter is that it not only declares certain rights and freedoms but, in addition, sets out in section 24 a mechanism for enforcing them. Basically, anyone who feels his rights or freedoms have been infringed or denied can apply to a judge for an appropriate remedy. The courts have broad latitude in shaping a remedy that fits the circumstances of the particular case. Such remedies may well include financial compensation, the granting of an injunction, or a judicial declaration that an otherwise proper law is no longer of any force or effect.

The Charter explicitly provides for that remedy which is most likely to be applied for in criminal proceedings; namely, that evidence obtained in a manner that contravened the accused's rights or freedoms be excluded from his trial. This remedy, however, is available only where the accused can establish that admission of the impugned evidence at his trial "would bring the administration of justice into disrepute." Our courts are now faced with the onerous task of breathing life into this critical part of the Constitution. The Americans, of course, have had an "exclusionary rule" (as the power to suppress otherwise relevant evidence is usually called) for many years. The Canadian exclusionary rule appears to be narrower in scope, requiring not only a violation of guaranteed rights or freedoms but, in addition, one that is sufficiently grave to impugn the integrity and public reputation of the judicial system.

To take an extreme example, if a seizure of marijuana was obtained as a result of systematic police torture, a court would likely reason that such conduct violates the conscience of the community. Consequently, the marijuana must be excluded to preserve the integrity of the judicial system.

On the other hand, a one-hour delay in advising an arrested person of his right to retain counsel where the responsible officer was summoned to other urgent duties may well be viewed as falling below the requisite Charter standard for the exclusion of evidence. Those infringements and denials of guaranteed rights and freedoms that fall between these two examples represent the grey area that will occupy the courts for many years.

While any consideration of the courts' direction is highly speculative at this early juncture, it is at least possible to identify some of those Charter areas where challenges are likely to arise. In the field of drug and alcohol enforcement, warrantless drug searches, writs of assistance, the Ontario RIDE (Reduce Impaired Driving Everywhere) program, and the breathanalysis legislation are certain to be closely scrutinized. These and other potential legal battlegrounds will be canvassed next month.

Mr Green is a Toronto Lawyer with the firm of Ruby and Edwardh. Mr Solomon, a professor of law at the University of Western Ontario, is also a consultant on legal issues to The Journal.

THE BACK PAGE

Gretzky scores against drugs

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Drug abusers confusing EAPs

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Drugs, alcohol, and the Charter — Part two

The Back Page

Prevention tops US health policy

By Harvey McConnell

WASHINGTON — A United States government initiative to help deal with the increase in teenage use of alcohol will be launched later this year.

Richard Schweiker, US secretary of health and human services, noted that 8,000 teenagers and young adults die in drinking-related accidents each year, another 40,000 suffer injuries.

"No human loss is more tragic than a young life, rich with promise, cut short. The killing must be stopped and we're the ones who have to stop it," he told the annual conference here of the Alcohol and Drug Problems Association of North America.

At the same time, Secretary Schweiker said he was hopeful — "not because alcohol and drug abuse problems are solved, but because we have come so far and accomplished so much during the past few years."

He noted "the federal role is being redefined and updated. Funds for support of your treatment and prevention services have been placed more directly in the hands of state governments through block grants."

While some aspects of the federal role are changing, however, other aspects remain, and the largest is research.

Without research the work of treatment, prevention, and education in the substance abuse field would be hampered, he said.

He stressed the institutes which make up the US Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) will not only survive, but the field will also have the kind of continuing federal research needed to carry on the work.

The role of the ADAMHA will be expanded. "First and foremost, there will be a continuing effort to learn the effects and consequences of alcohol and drug abuse. We don't yet fully understand the interaction of biological and social factors that lead to drug and alcohol abuse and dependence, nor why some groups seem more or less vulnerable."

At the US National Institute on Drug Abuse (NIDA), priority will be given to learning more about the health consequences of mari-

(See — Prevention — page 2)

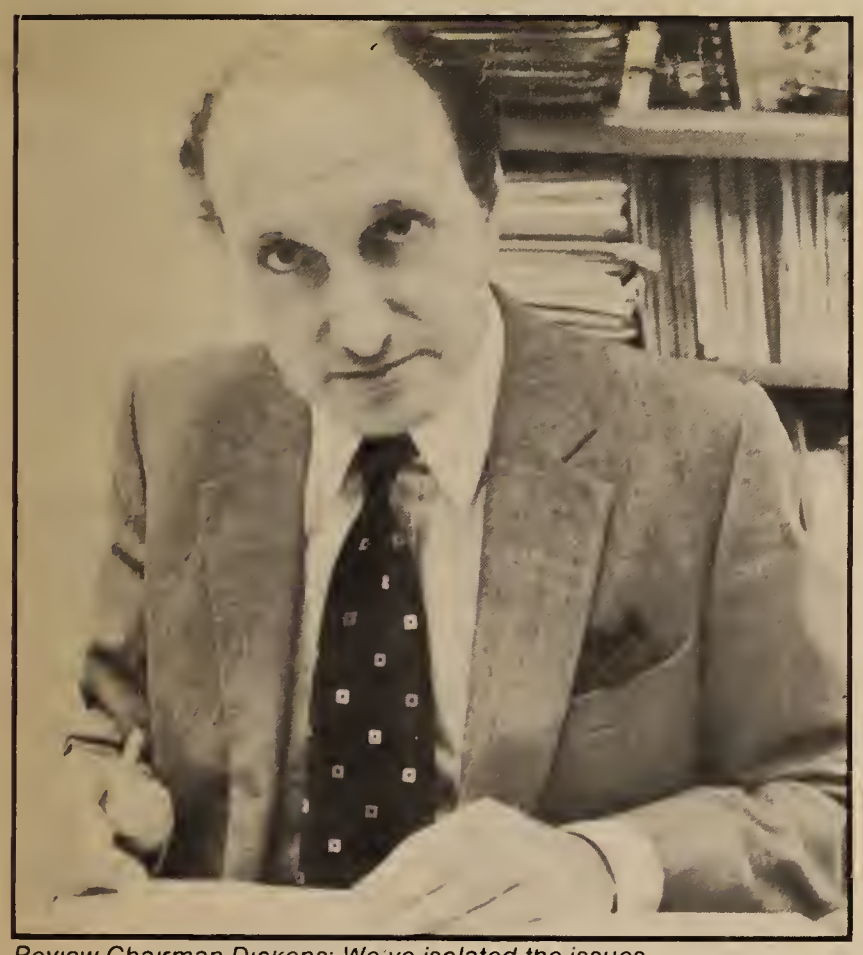
Schweiker. Killing must stop.

Vol. 11 No. 10 2nd Class Mail Reg No. 2776 TORONTO October 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Complexities of the Sobell review prolonging investigation: Dickens



Review Chairman Dickens: We've isolated the issues.

By Karin Maltby

TORONTO — The committee empowered to scrutinize research conducted by Mark and Linda Sobell in the early 1970s expects to report its findings to Addiction Research Foundation (ARF) President Joan Marshman later this month.

The complexity and number of issues surrounding the landmark, controlled drinking work of the husband-and-wife team have made it necessary for the External Review Committee (**The Journal**, Aug), to extend its informal target date, Chairman Bernard Dickens, PhD, LLD, told **The Journal**.

"I think we've isolated the issues, and we're getting some sense of how it's shaping up," said Dr Dickens, professor of law, faculty of law, at the University of Toronto here.

The review committee was set up by Dr Marshman last May. The Sobells requested an independent enquiry be made when they first learned of an article to be published in *Science* magazine that challenged their controlled drinking work.

Dr Dickens said the review committee has met with various experts including people from the ARF, and invited input from others.

As of mid-September, however, Mary Pendery, PhD, senior author of the *Science* article, had declined Dr Dickens' invitation to meet the committee in Toronto. She told **The Journal** she was also likely to deny a recent request from the chairman for specific extracts of documentation she has gathered in the past 10 years.

The Pendery et al work was published in the July 9 issue of *Science*. Its findings, contradicting the Sobells' work at Patton State Hospital, Patton, Ca, in 1970 and 1971, aroused the scientific community. While the Sobells claimed to have successfully trained a group of gamma (physically dependent) alcoholics to control their drinking, Pendery et al maintain the group failed to do so from the outset.

In a statement prepared for **The Journal**, Dr Pendery described her reasons for failing to partcipate in the work of the review committee:

"The reason that it (the committee) did not seem to be an appropriate forum for me to participate in was, in part, that it accepted a mandate it does not have the judicial powers to fulfill; namely, to judge the Sobells' state of mind 10 years ago, that is, whether or not (there was) intentional, willful, or deliberate misrepresentation or misconduct.

"My advisers will permit me to participate in an impartial forum, preferably one which has the authority to require sworn testimony, and to subpoena witnesses," said Dr Pendery, a psychologist at the Veterans Administration Medical Center, San Diego, Ca.

(See — Second — page 2)

Traffickers being worn down as Florida closes drug pipeline

By Harvey McConnell

WASHINGTON — The United States government's mammoth effort to interrupt the flow of illegal drugs into south Florida is working and traffickers are hurting.

"We have had a tremendous success in doing what we have set out to do — reduce the flow of drugs coming through south Florida," Carlton Turner, director of the White House Drug Abuse Policy Office, told **The Journal**.

Dr Turner said some people still don't realize "that when you have a pipeline with an open tap coming into this country in an area as long as south Florida, you can't turn it off overnight. Everyone expects the quick fix, but we know the quick fix can get you into much more trouble.

"As the President (Ronald Reagan) has said, and the Vice President (George Bush) has said, we are going to keep the pressure on, and we are beginning to see changes. We are gradually going to wear them down." (**The Journal**, April).

(See — Assembly — page 2)

Turner: No quick fix.

INSIDE

NEWS

Briefly...

Fatal link

LANSING, MI — Michigan State Police report that of 839 drivers involved in fatal car accidents during 1981, only 289 had not been drinking prior to the crash. Of the 553 drivers who had been drinking, only 19% registered a blood alcohol level (BAL) of less than 0.10%. Eighty-one per cent of the drunk drivers registered BALs of 0.10% or higher, and of this 81%, nearly half registered 0.20% or higher.

Prof bans smokers

HAMILTON — An associate professor of anatomy at McMaster University here says he will not allow medical students who are smokers to participate in his classes. A non-smoker for 30 years, George Lewis, 62, says "if (medical students) are not willing to act according to the soundest medical evidence we have ever had, then they should not be in medicine." However, Jack Laidlaw, dean of the health sciences faculty, doesn't believe Mr Lewis will be able to maintain his stance although there is no official policy on the issue. "I'd be more concerned about a medical student who was unkind to other people . . . If they smoke by themselves, or with other smokers, they only hurt themselves," says Dr Laidlaw.

Co-author awarded

LOS ANGELES — A co-author of an article which contradicts early research on controlled drinking in the United States (The Journal, Aug), is the recipient of the Walter C. Alvarez Memorial Award from the American Medical Writers Association. Dr Louis Jolyon West, director of the Neuropsychiatric Institute at the University of California here, has written or edited more than 120 papers as well as six books.

Arthritis treatment?

HOUSTON, TX — An 82-year-old great-grandmother has been sentenced to two years unsupervised probation following her conviction for possession of marijuana. The woman testified she had been growing the plants in her garden and using the marijuana as a treatment for her arthritis. District Judge Mike McSpadden told her: "The only condition on your probation is that you give me a call every couple of months and tell me how you're doing."

Inmates surveyed

MEXICO CITY — A survey taken to determine the prevalence of drug use among prison inmates in Mexico shows that 25.7% of the inmates have had experience with some drugs. The substances most frequently consumed were: cannabis (47%), sedatives (28%), and inhalants (11%). The remainder was distributed among cocaine, amphetamines, and various kinds of opiates and hallucinogens. The total sample consisted of 8,341 male and female prisoners in 30 Social Rehabilitation Centres located in 17 different cities in the country.

Second Sobell review now suggested in US

(from page 1)

She added that the findings of the review committee can only be "indeterminate" without her participation.

The mandate of the review committee is to conduct a thorough review of the original Sobell research and follow-up studies; to consider the Pendery et al criticism and other relevant material; and to allow the Sobells an opportunity for a rebuttal.

Meanwhile, in the United States, a separate investigation may be carried out because the Sobells received federal grant monies to conduct both the Patton project and other studies.

Jim Jenson, investigator for the sub-committee on investigations of the Committee on Science and Technology of the US House of Representatives, told **The Journal** that recent US government regulations require that any allegations of scientific misconduct, where public money is involved, be investigated.

It is the sub-committee's job to tell the funding body that questions about research have been raised, and to ensure that an investigation is conducted, Mr Jenson said.

In the Sobell case, Richard Schweiker, secretary of the department of health and human services (DHHS), was notified of the allegations that appeared in *Science*, and elsewhere, by sub-committee chief Albert Gore, a Tennessee Congressman.

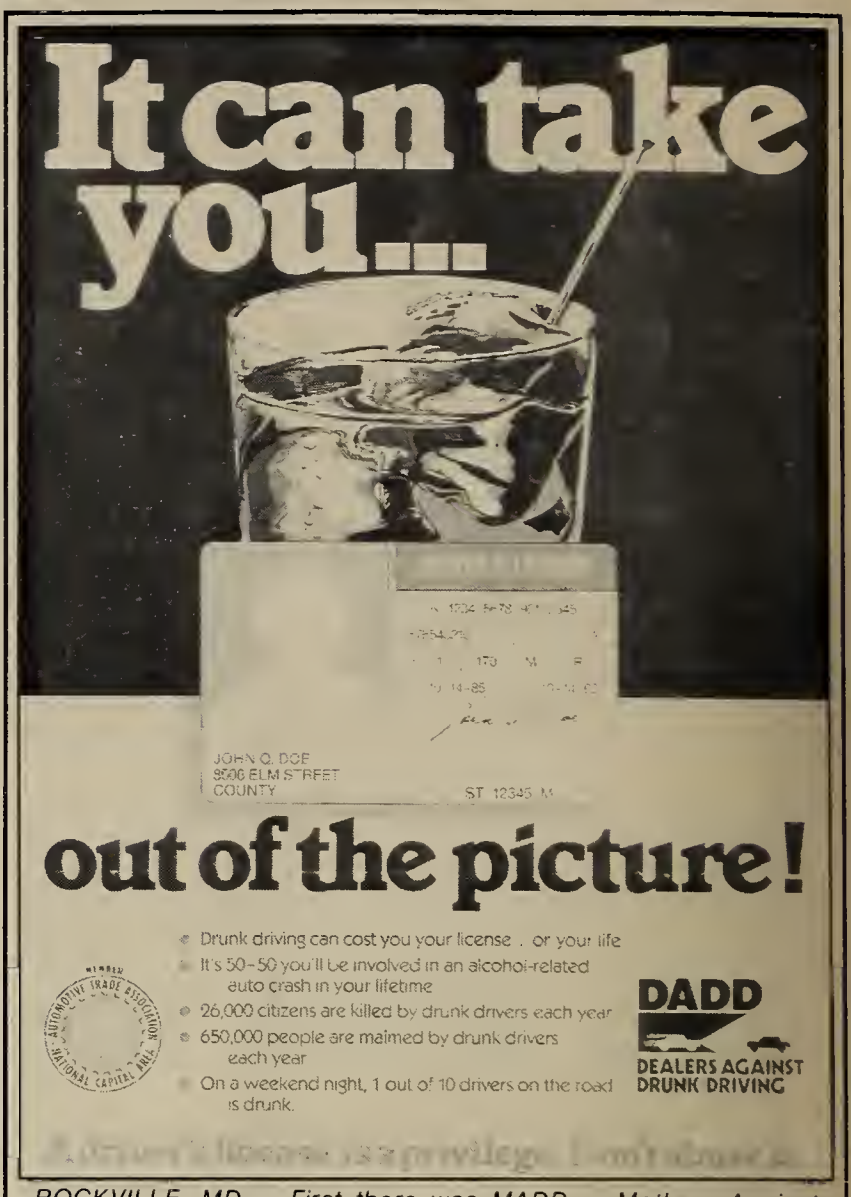
He asked Secretary Schweiker to detail his plans for the investigation to the sub-committee, and to supply information about any additional DHHS funding the Sobells may have received for other studies following the Patton project.

Mr Jenson explained that since the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) was involved in granting money to the Sobells under the umbrella DHHS, the NIAAA would be the body responsible for conducting the investigation.

The Sobells left the US to accept posts at the ARF in 1980: Mark Sobell, PhD, as Head, Socio-Behavioral Treatment Research, and Linda Sobell, PhD, as Head, Behavioral Intervention Research.

Meanwhile, Irving Maltzman, PhD, second author of the Pendery article, told **The Journal** another article challenging the methodological techniques employed by the Sobells is now under way.

There is no scheduled completion date for the latest work, said Dr Maltzman, of the department of psychology at the University of California, Los Angeles.



ROCKVILLE, MD — First there was MADD — Mothers Against Drunk Drivers. Then came SADD — Students Against Drunk Drivers. Now there is DADD — Dealers Against Drunk Drivers. The group, which is rooted in Montgomery County, will provide posters like this for display in car dealership windows. Also planned are an education campaign for sales people, and public service announcements on radio.

Assembly lines need clear thinkers, says Turner

(from page 1)

The fact many more people are being caught trying to smuggle cocaine within their bodies signals to Dr Turner "they are having difficulty moving the stuff. If they are willing to take the chance of a half-pound bag being in the abdominal cavity of a human being then somebody is hurting." (**The Journal**, June).

Dr Turner, who is now overall inter-agency director in the administration's fight against drug abuse, said there are encouraging signs of increased efforts by several Latin American countries to reduce drug shipments north.

He said he has also been gratified, and at times surprised, by the support from the private sector in the fight against drug abuse within the US.

"Many have said the private sector can't pick up this, and can't pick up that. But if you look at the bottom line, industries in this country pay for the cost of drug abuse in sloppy workmanship, days lost from the job, and low productivity, and now they are willing to put the money out to do something about it.

"I have never seen such an outpouring of support throughout the country as I have for this program to control drugs.

"Mrs (Nancy) Reagan has gotten unbelievable support in her efforts and people keep calling to ask what they can do."

The knowledge that drug use and abuse is hurting not only the individual but also the community has permeated to the grassroots. Industry has now awakened to the fact that "with more sophisticated instrumentation and assembly lines we have got to have people with clear thinking running the assembly lines," Dr Turner said.

"It is a fight to prevent us from losing a generation and losing our economic battles from outside as well."

Dr Turner said he believes urine testing for drug use (**The Journal**, July) in the military and industry "is one of the best things to come down the pike in years.

"Now as a policy maker I am not going to go out and say industry must do this. I am just saying this is another tool in the area of prevention or intervention we didn't have two years ago."

About the recent federal tax increase on tobacco passed by Congress, Dr Turner said daily cigarette use among young people had declined "and I think anything we do to prevent young people from using drugs of any kind until they are mature is a step in the right direction."

Prevention 'most important word' in vocabulary of health policy

(from page 1)

juana and cocaine use, especially among children, adolescents, young women of childbearing age, and unborn babies.

Work will continue with the military on the impact of drug use on members of the armed forces.

Secretary Schweiker said emphasis will continue to be placed on diagnostic techniques "knowing as we do that the earlier the treatment, the greater the likelihood of success. We will continue to seek reliable diagnostic tools that can be used by general practitioners and others early and inexpensively."

More work will also be done on the problems of alcoholism and drug abuse in business and industry.

A new clinical research ward will be opened by the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) on the campus of the National Institute of Health early in 1983. A building will be provided in Baltimore for use by the NIDA as a consolidated and expanded addiction research program.

Secretary Schweiker said: "Prevention to me is the most important word in the entire vocabulary of health policy. Years ago, as a US senator, I preached again and again the value of health prevention and disease prevention."

Today, as the US's top-ranking health official, "I've put health promotion — or wellness as I call it — at the top of America's health agenda."

Teenage drug abuse had received wide public attention since the 1960s "but recently we've learned how serious a problem alcohol abuse is among teenagers as well." Most alarming is the way teen alcohol abuse is increasing.

Secretary Schweiker said his teenage alcohol initiative will find strong allies in the grassroots organizations of parents formed around the nation in recent years. (**The Journal**, July, Aug).

"Traditionally, when an American community faced an outside danger, its citizens banded together for protection. Today the danger of drug and alcohol abuse lies within our communities. That's where much of the protection must come from."

But community action must be backed by national public education, and drug and alcohol abuse will continue to feature in his department's prevention strategy.

NEWS

Medical use of heroin a minor issue

Proposed pain group appointment irks activist

By Rhonda Birenbaum

OTTAWA — The proposed appointment of Robert Macbeth as chairman of a pain-management committee has bewildered an Ontario physician who has crusaded to have heroin legalized for medical use.

The committee has been charged by Health and Welfare Minister Monique Begin to look at all pain-killing drugs — including heroin — and to establish a therapeutic monograph for Canadian doctors on effective management of pain (**The Journal**, Sept).

However, Kenneth Walker, who met Ms Begin this past summer armed with more than 20,000 petitions asking that heroin be legalized, told **The Journal**: "I wouldn't pick Macbeth and I don't know why (Ms) Begin did."

Dr Macbeth, a senior executive of the Canadian Cancer Society has already investigated the medical use of heroin and has taken a stand against legalization.

In 1980 he led a cancer society "literature review" on the use of heroin and concluded "it has no unique features to make it a necessary addition to the physician's armamentarium."

Ian Henderson, director of the bureau of drugs, and the man responsible for coordinating the committee under the direction of Ms Begin said, however, that Dr Macbeth has been recommended because of "his experience in handling pain," and not because of his previous anti-heroin statements.

Dr Henderson added that "90% of what the committee will do will have nothing to do with heroin. Their biggest role is pain relief — that is, the assessment of other drugs for pain control."

Dr Macbeth had not been contacted regarding the post by mid-Sept, and the position was contingent on his acceptance. It was at Ms Begin's suggestion that Dr Macbeth be invited to join the committee.

Heroin was banned in Canada following a World Health Organization (WHO) recommendation in 1955 to outlaw the drug for all purposes including pain relief. It is medically available, however, in Great Britain, New Zealand, China, and West Germany, among others.

Following Ms Begin's meeting with Dr Walker, she agreed to ask the WHO to reconsider the ban. Establishment of the pain-control committee is one stage in the health minister's preparation for the WHO.

Dr Henderson said the committee will meet for about four days later this fall. Assisting the committee will be a number of consultants with direct experience in the medical use of heroin. Since few Canadians have experience with the drug, the consultants will likely be physicians who have worked in other countries, Dr Henderson added.

New THC tests are 'promising'

By Mark Kearney

TORONTO — A scientist at the University of California at Los Angeles (UCLA) claims he has developed the first reliable saliva and breath tests to detect delta-9-tetrahydrocannabinol (THC), the active ingredient in marijuana.

Stanley Gross, professor of anatomy at UCLA's school of medicine, says he and three colleagues developed the tests in the past year at the Receptor Research Laboratory, an independent facility in Glendale, Ca. His co-workers on the study, sponsored by the United States National Institute on Drug Abuse, are Drs Emery Zimmermann, James Grant, and James Soares.

Considerable interest in the findings has been shown by US government and law enforcement officials because the tests don't require an invasive procedure, Dr Gross told **The Journal**. Many present tests involve taking urine or blood samples.

The saliva test involves taking a sample from a person's mouth with a cotton swab or having the person spit onto something and then dipping the swab into it, he says. In the breath test a person blows into a polymer matrix filter which captures the THC. Dr Gross declined to give details on what polymer is used.

Once the samples are taken a laboratory can analyse the results within a few hours using a testing unit that costs only about $17, Dr Gross says.

However, the tests must be taken within a few hours of marijuana use since the THC levels in the breath and saliva are similar to those in the blood rather than the urine. THC levels can remain high in the urine for several days after a person has smoked.

Dr Gross believes the time needed to carry out the tests won't be an impediment to their use in legal matters. If a person feels he has a right not to be detained while the tests are being analysed, police can contact the person later with the results, he says.

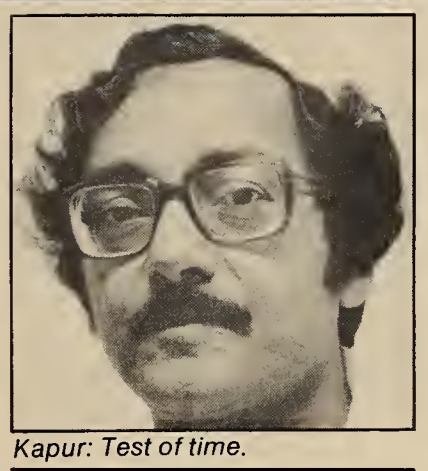
Both tests were tried on between 200 and 250 subjects and showed no false positives or false negatives, Dr Gross says. Tests were also done to see if people exposed to sidestream smoke (the smoke from the burning end of a cigarette and that is neither inhaled nor exhaled) would have THC levels in their saliva or breath. They were negative.

"If there is THC (in the test results) then it means the person has smoked," he says.

Dr Gross claims his tests are several times more sensitive than urinalysis tests. While a person who has had a single puff of an average-strength marijuana cigarette wouldn't be detected by the test, one who has smoked half a cigarette would, he says.

Other researchers are viewing Dr Gross' claim with, at best, only cautious optimism.

Bhushan Kapur, director of clinical laboratories at Ontario's Addiction Research Foundation (ARF), says he would like more details on the UCLA team's findings. While the test may show some people have smoked marijuana, could everyone be detected by it, he asked.



Kapur: Test of time.

"Yes, it's an exciting new find, but will it bear the test of time?" Dr Kapur told **The Journal**.

Linda McBurney, a biochemist for the Defence and Civil Institute of Environmental Medicine in Downsview, Ont, did breath testing for THC earlier this year and found the results varied widely only 20 minutes after marijuana use.

Dr Gross' results are "technically feasible" but more proof and independent testing are needed, she says.

Dr Gross admits there are still refinements needed for his breath test, but says the saliva test has already received US Food and Drug Administration approval for marketing.

He says the tests will provide the short-term results law enforcement agencies are looking for and will help reduce controversies in the court about whether a person has smoked or not. Dr Gross has no idea how long it will be before the tests are put to regular use.

For younger non-smoking women

Benefits of 'the pill' outweigh risks: study

TORONTO — The birth control pill can prevent certain serious diseases, including two cancers, for non-smoking women younger than age 35, says Howard Ory of the Center for Disease Control in Atlanta.

After reviewing literature covering studies of hundreds of thousands of women, Dr Ory concludes 'the pill' seems to curb arthritis, ovarian and endometrial (lining of the uterus) cancer, benign breast disease, ovarian cysts, anemia, infection of the fallopian tubes, and ectopic pregnancy.

He says he wasn't surprised by his findings and notes that too often the media point out the health risks of the pill without mentioning the benefits.

While it's true the pill can be associated with such problems as cardiovascular disease for women older than age 35, who smoke, Dr Ory suggests that for most pill users the benefits outweigh the risks.

Dr Ory told **The Journal** he couldn't predict whether his study will lead to greater use of the birth control pill, but he will be monitoring any change in trends.

Dr Ory, deputy director of the centre's family planning evaluation division, will continue to review literature on the pill for follow-up reports.

His work was first published in the August issue of *Family Planning Perspectives*, the journal of the Alan Guttmacher Institute, an affiliate of the Planned Parenthood Federation of America.

Social scientists face methodological traps

By Wayne Howell

Physics is a pure science. The physicist unlocks the secrets of natural law and then creates a mathematical equation to serve forever after as a key to the understanding of a natural phenomenon. Once his hypothesis has been proved in the lab, his prognostications become unassailable, or virtually so. When he discovers how mathematically to represent a coefficient of friction, he can predict with great assurance the terminal velocity of every wooden block that ever slides down an inclined plane in a high school physics lab.

Pity the poor social scientist; armed with reams and reams of anthropological, sociological, and psychological data — enough to bury the physicist in his lab — he still cannot predict with any degree of accuracy which person growing up in a log cabin, or ghetto equivalent, will become president and which will end up in a methadone maintenance program. Often his prognostications are on a par with those of soothsayers.

Science loses its purity — and hence its ability to make accurate predictions — as soon as it leaves the inanimate world and concerns itself with animate matter.

The biology lab, for instance, is a far cry from the physics lab. Even if one studies the simplest, one-celled creatures one is faced with idiosyncracy; the amoeba may not perform as expected because the experimental milieu doesn't *feel right* — it is too hot, too cold, too dark, or too bright. And when the biological scientist starts to experiment with human subjects his problems increase in exponential fashion. What is to be made, for instance, of clinical trials of analgesics in which pharmacologically inert placebos consistently show effectiveness rates of 40% or more, clinical trials that have to be done in the expensive, cumbersome, double-blind manner so that the *feelings*, *hopes*, and *aspirations* of both the experimenters and the experimented-upon won't conspire to produce misleading results?

At least the biological scientist has got some objective indices he can rely upon, such as blood pressure changes, skin temperature changes, etc. More often than not the social scientist is denied even these tenuous links with the pure science of the physics lab; quite often the only factors in his analysis are the irascible, perverse, human ones.

He has to work in a world where even such a simple thing as a personality test can be totally misleading unless it is cunningly conceived so as to identify those human subjects who, for one reason or another, are "faking good," "faking bad," or just lying for the hell of it; a world where he can never even be sure his test subjects are truly representative of their group, since the fact that they were willing to participate in his experiment may in itself indicate a deviation from the norm. His work is threatened by methodological minefields that have no counterpart in the orderly world of the physics lab.

Given the difficulties inherent in the practice of the social sciences, one cannot help thinking of Samuel Johnson's remark about the dog walking on its hind legs: whether or not it is done well is not really the issue, you are surprised to find that it can be done at all.

In view of this, it is not all that remarkable that social sciences produces more than its share of scientific brouhahas, such as the current controversy about the merits of the decade-old work on controlled drinking by Drs Mark and Linda Sobell. Such brouhahas should not obscure the fact that the dog is up and walking, albeit a little unsteadily at times, in a forward direction.

NEWS

RESEARCH UPDATE

Caffeine withdrawal in some newborns?

During the last month of pregnancy there is a sharp decline in the body's ability to eliminate caffeine, indicates a study of 15 women in their final few weeks of pregnancy. After avoiding caffeine-containing foods for 24 hours, the women had a morning cup of tea or coffee. Saliva caffeine (which closely reflects blood caffeine levels) was monitored for the next 20 hours. The average half-life of caffeine in non-pregnant women has been previously shown to be six hours but with these pregnant women it took 21.5 hours on average for the amount of caffeine in saliva to drop by half. Smoking speeds caffeine elimination, but while caffeine half-life in non-pregnant female smokers has been shown to be 3.5 hours, the pregnant smokers in this study had a 9.6-hour caffeine half-life. Since caffeine readily crosses the placental barrier, the fetus of the mother who continues normal coffee-drinking would also be exposed to high caffeine levels and the newborn could experience withdrawal, say Drs William Parsons and Jean Guy Pelletier.

Canadian Medical Association Journal, Sept 1982, v 127: 377-380.

Gum that gives you a lift

Chewing nicotine gum provides a steadier blood nicotine level than does cigarette smoking, indicates a study of 12 smokers who agreed to switch to nicotine gum for a six-day period. With cigarettes, the researchers found, the peak of blood nicotine is reached within five minutes of lighting up while, with gum, blood nicotine typically peaks after about 20 minutes of chewing and then declines slowly. The researchers also found that many of their subjects preferred the high-strength nicotine gum (4 mg nicotine per stick); it kept blood nicotine levels above those created by their smoking patterns.

Journal of the American Medical Association, Aug 20, 1982, v 248:865-868.

Gamblers get the shakes

Between 30% and 40% of gamblers who quit go through some symptoms resembling withdrawal, indicates a study of members of Gamblers Anonymous in the United Kingdom. Disturbances of mood — such as feeling irritable, restless, unable to concentrate, anxious — were most widely reported but 39% also said that they had experienced, on quitting, at least one physical symptom such as nausea, shakes, chest pain, or muscle cramps. "If you took 100 statements from gamblers who had stopped gambling, and 100 from drinkers who had stopped drinking, I'd say you would find it hard to tell the difference between the two groups," *The Medical Post* (Aug 10, 1982) quotes one of the researchers as saying.

British Journal of Addiction, 1981, v 76:401-405.

Two kinds of alcoholism

Alcoholism takes two quite different forms, suggests C. Robert Cloninger, professor of psychiatry at Washington University, St Louis. On the basis of patterns he has observed in his clinical work, Dr Cloninger suggests Type I alcoholics typically progress slowly from controlled drinking in early adulthood to abuse by middle age, still managing, however, to hold onto job and social standing. By contrast, Type II, who are outnumbered three to one by Type I and are nearly always male, are abusers in adolescence and have far greater capacity for drink. The risk for Type I is winding up in hospital with liver problems; Type II aren't troubled by their livers but their tendency to be violent when drunk often gets them sacked and jailed.

Medical World News, Aug 2, 1982: 88-89.

"Antabuse" as a probation condition

Supervised administration of disulfiram (Antabuse), as a condition of probation for those who tend to be violent when drunk, "could reduce overcrowding in prisons and help with the rehabilitation of individual alcoholic offenders," suggest an alcoholism therapist and a probation worker from London, England. Colin Brewer and W. J. Smith note that since disulfiram administration doesn't require inpatient treatment, it is an economical approach. Also, since effects last up to a week, if the patient misses an appointment there is still a good chance of intervening before the patient can drink again.

The Lancet, July 31, 1982: 271.

PCP in infants

Phencyclidine, also known as PCP and "angel dust," can readily be transferred to the baby *in utero*, indicates a study. It found that blood samples from the umbilical cord were positive for PCP in 92% of cases when blood from the mother contained the drug. The study done in an obstetrics ward at University of Southern California Medical Center in Los Angeles, was headed by Dr Kenneth R. Kaufman, and involved 200 new mothers. Twenty-six mothers and 24 cord blood samples were PCP-positive. PCP is known to produce some chromosome breakage in users and is a source of fetal abnormalities and increased fetal loss. In this study, no increased incidence of gross abnormalities was detected and the fetal loss question could not be addressed as only pregnancies successfully carried to term were considered. The researchers noted, however, that the sex ratio among PCP-exposed babies was disproportionately weighted toward females. A particularly troubling aspect of PCP exposure, the researchers say, is that the drug metabolizes very slowly, so mothers taking it even before conception could pass it on to their babies.

Paper given at American Psychiatric Association annual meeting, Toronto, May 1982

Austin Rand

Education and social change best tools against alcohol

By Lynn Payer

MUNICH — World-wide problems with alcohol misuse won't be eradicated in a few years, or even a few decades, by simplistic devices such as advertising restrictions and increased taxes, says David J. Pittman, PhD.

"The problem did not develop since 1950 (or) since 1920, but has been an almost constant theme in the last few centuries of western civilization," Dr Pittman, chairman of the department of sociology at Washington University in St Louis, Mo, told the 28th International Institute on the Prevention and Treatment of Alcoholism here.

"It is not going to be eradicated by simplistic and cosmetic devices that will run to the year 1990 or 2000. This is a long-range problem."

Dr Pittman said most programs for primary prevention could fit under five general headings; prohibition, education, control of consumption of alcohol, development of replacements for drinking, and changes in the social structure of a society.

"In culturally pluralistic societies such as those in the United States, Canada, and Western Europe, primary prevention of alcoholism, and alcohol abuse programs, will be most effective" if emphasis is placed on education and changes in the social structure of society, he said.

He noted, however, it is difficult to prove that education is an effective means of primary prevention.

"The basic assumption behind the model is that the dissemination of information influences and changes attitudes, values, and behaviors of individuals and groups. The empirical research to support this contention is sparse and inconclusive because systematic evaluation of the effect of these programs has not occurred to any significant degree due to the long time-period necessary to collect systematic data."

Prevention projects of the US government, he said, have a three-year time limit, and evaluation of change in this short period is almost impossible.

As to changes in the structure of society, Dr Pittman said resources should focus on groups in the population that are either at greater risk or are more vulnerable to alcohol problems. In US society, he said, this would mean targeting prevention programs at minority groups such as native Americans, male homosexuals, and lower income blacks, as well as groups that occupy ambiguous status positions, such as women and youth.

Pittman

The latter approach, he said, is based on the fact alcohol misuse is not randomly distributed in US society but is more likely to be found in certain groups.

This is a "precision-rifle prevention technique, as opposed to the shotgun approach that the control-of-consumption advocates use," whether drinking problems exist in the various subgroups or not.

Dr Pittman: "Sociologically, we would hypothesize that attitudinal and legal changes which would provide all groups in the US with full access to the rights and privileges of the society should have an impact on reducing their problems of alcohol misuse. Although idealistic, all discriminatory laws and practices directed at any American, especially those in disesteemed or stigmatized positions, should be repealed, if by law, and eradicated, if by custom and practice."

Police probe pharmacy break-ins

TORONTO — Pharmacies will have to beef up their security systems to battle the worsening problem of store break-ins, says Rick Morrison of the Ontario Provincial Police.

There has been an average of 40 drugstore break-ins a month in Ontario this year, with about 85% occurring in Toronto. Better locks, alarm systems, and improved cooperation between pharmacists and police may help fight the problem, he said at the recent Council on Drug Abuse conference here.

Cpl Morrison says the problem is getting worse because people are finding it easier to get their drugs from a store than having to find and pay for them on the street. Main drugs being stolen are Percodan, codeine, morphine, and Valium, he says.

The highest number of break-ins in one month last year was 48 whereas this year January and February had 58 and 60 respectively. The number has decreased since then but Cpl Morrison isn't sure why the problem seems to be worse in the winter.

The problem is similar in the United States, but there tend to be more armed robberies of drugstores there, he says. In some cases, pharmacists in the US have had to work behind bullet-proof glass.

Cpl Morrison says the break-ins usually take place late at night and "the people know exactly where to go and what to take."

The thieves usually work in teams of five, he says, with one breaking the lock, two to keep a lookout, and two others who are familiar with drugstores and their layout.

"The break-and-enter guys plan (the crimes) very intricately. It's amazing. They can do the job within minutes."

Cpl Morrison says the police are also facing an increasing problem with double-doctoring. In these cases, a person gets a prescription for a certain drug from one doctor and then goes to another doctor to get the prescription again.

These individuals usually intimidate a doctor into giving out a prescription by describing the symptoms of their problem in detail. The doctor, who is unfamiliar with the patient, may be impressed enough by this description to prescribe the drugs the person wants.

The police have a special squad working on this problem, Cpl Morrison says, and ask pharmacists to fill out monthly reports as to who is getting drugs from their respective stores.

Heroin deaths in Michigan are tied to poor economy

LANSING, MI — The high purity of heroin being sold on the streets in the Detroit area could be a factor in the reported increase in overdose deaths here.

The Michigan Office of Substance Abuse Services (OSAS) says there has been a steady increase in Wayne County of narcotics-related deaths between April 1 and June 14 of this year — the highest narcotics death toll for a similar period since 1976.

The increase in deaths may also reflect increases in the availability and use of heroin in Wayne County, says OSAS Evaluation Section Chief Dick Calkins.

At the same time, because of service reductions and funding priorities, there are fewer current opiate treatment admissions as compared with those of a year ago. There were 1,161 people admitted to Wayne County treatment programs with an opiate/heroin problem during April through June of this year.

Mr Calkins: "However, the admissions statistics show a steady increase in the unemployment rate among the opiate/heroin clients — which reached 77% during the past quarter.

"It is possible, therefore, that the increased death and overdose rate could also be related to the poor economic situation and high unemployment rate in Wayne County."

Instant fines to cannabis smugglers in UK test

LONDON — British customs agents now have the power to impose on-the-spot fines for people caught trying to smuggle small amounts of marijuana into the country.

The experiment by Customs and Excise is aimed at cutting down on the time and cost of court proceedings. It is being limited to London's Heathrow and Gatwick airports.

Under the system, a passenger caught with up to 10 grams (0.32 oz) of cannabis will be given the chance to pay a fine to the customs officers as an alternative to prosecution.

The fines will be imposed under existing legislation which, for a long time, has allowed customs officers such authority in minor cases of smuggling of watches, jewellery, alcohol, or tobacco, and of prohibited items such as CB (Citizen Band) radios and pornography.

NEWS AND COMMENT

Alberta launches lifestyles magazine for teens

By Austin Rand

TORONTO — Can a bright, breezy, soft-sell magazine aimed at teenagers influence the coming generation toward a lifestyle free of alcohol and drug misuse?

Quite possibly, says the Alberta Alcohol and Drug Abuse Commission, (AADAC), which has made the magazine — *Zoot Capri* — the centrepiece of a $2.4 million, two-year media campaign which will include radio and television spots.

Zoot Capri will actually take the smallest bite out of the budget, but it's the magazine that has been getting most of the attention.

"People have such strong expectations about what an addictions-related agency is likely to publish that I think they're surprised by the magazine," Ric Durrant, AADAC communications manager, told **The Journal**.

The publication, which is standard magazine size, runs to 48 pages and has full-color photos and graphics. Contents of the first issue range from a cartoon sequence through record reviews by teenagers, a section on "hot" (active and attractive) Alberta kids, and items on things to do out of school, to feature articles on topics such as living in the shadow of a famous older brother or sister, visiting Australia, and the effects of alcohol on driving ability.

Many of the articles do not touch on alcohol and drugs at all; in the rest, the message is implicit rather than explicit.

"We aren't focusing on alcohol or drugs but on a more general process, of which alcohol and drug use is an example," Mr Durrant explained.

"What we are trying to do is to help adolescents sort out the basic life task they face — the process of becoming a responsible adult, changing from being cared for to a situation where you learn basically to care for yourself. The theme is 'responsible independence' and the articles tend to illustrate the consequences of certain ways of acting, including the ways you approach alcohol or drugs."

To develop the magazine and the radio-TV campaign, the AADAC turned to a private sector company, West-Can Communications, of Edmonton.

"We had doubts the AADAC could, on its own, establish such a magazine as a very attractive piece of media for a teenage audience," Mr Durrant said.

Evaluations of the radio and TV spots, as well as of the magazine, indicate the campaign — particularly the magazine — is being well-received by the 14- to 16-year-olds who are the primary target.

Fifty-thousand teenagers received the first issue of *Zoot Capri*, this past summer, and the target number of 90,000 to 100,000 teenagers — the great majority of Albertans in that age range — will probably be reached within two or three issues, Mr Durrant said.

The present plan is for quarterly issues but that could shift to bi-monthly or even monthly publication, depending on finances and reader response, he said.

Whether advertising will be included in the magazine is an issue that hadn't yet been resolved, he added.

The only major criticism raised so far by the teenagers themselves, said Mr Durrant, is from boys who feel there isn't enough sports coverage in the magazine.

The magazine costs up to $150,000 per issue and is given away free, but the AADAC has so far heard no complaints about misusing taxpayer's money, Mr Durrant said.

Plans are also to focus on Alberta rather than on Western Canada or Canada in general.

"We wanted a magazine that kids in Alberta would feel was very special for them and about them. We hope that if you are a teenager in Alberta and you get *Zoot Capri* then you will come to feel that someone you know, or maybe even you, could be in the magazine."

And what does *Zoot Capri* mean?

"One of the people in the advertising agency thought it was a neat name for a magazine. We thought so too, and the kids agreed."

Zits Zantini: Central character.

GILBERT

'. . . a likely fate of the report will be a dusty shelf.'

Smoking and health in Ontario

By Richard Gilbert

My title is also the first part of the title of a recently issued report of a task force on smoking established by the Ontario Council of Health in 1980. The other part of the report's title is "A Need for Balance."

I was a member of the task force along with nine others — including researchers, physicians, public health specialists, community activists, and others with an interest in advising the Ontario government as to how public health might be improved through doing something about smoking. The chairman was Dr Allan Best of the University of Waterloo. (An interview with him about the work of the task force appeared in **The Journal** in May, 1982.) Provincial and federal health ministries had official observers who were active participants in the development of the final report.

I have already discussed three of the report's recommendations in earlier columns this year, although not specifically as coming from the task force.

In April I wrote about the relationship between the price of cigarettes and their consumption, noting that probably the most effective way of reducing cigarette use in Canada (or anywhere else) would be to raise the real retail price. I noted that a doubling of price in three stages in the course of a year would have the effect of halving cigarette consumption, if the historic relationship between price and consumption were to continue. The task force recommended that "the retail price of cigarettes be doubled within a 12-month period by means of three, phased increases in basic taxation on tobacco products" and that through taxation the price of cigarettes be kept up with inflation thereafter.

No priority

The task force did not give priority to any of its 12 recommendations, but it noted that the recommendaton on price and one other "stood out." Of the measures proposed, said the task force, "increased taxation will have the greatest effect on smoking in Ontario."

In May I wrote about the relationship between the weight of cigarettes and their consumption. I suggested that most of the more than doubling in per capita cigarette use in Canada since 1949 could be explained in terms of a reduction in the amount of tobacco per cigarette. There is less tobacco now because filter tips take up some of the space, and because the tobacco is fluffed and puffed more than it used to be. (When I wrote the May column, I had only United States data to go on. Since then I have been shown data indicating that the weight of tobacco in the average Canadian cigarette fell by 54% between 1949 and 1980, from 1.88 to 0.87 grams.) A reason given by manufacturers for adding filter tips and using less tobacco is that the resulting cigarettes raise fewer concerns about health. But, said the task force, "a key issue is whether or not 'less hazardous' smoking is in fact less hazardous . . . manufacturers increasingly are marketing cigarettes that supposedly deliver less tar and nicotine, but at least some smokers may not take in less." The task force recommended that "research leading directly to the further laboratory evaluation and field testing of 'less hazardous' uses of tobacco and tobacco substitutes be given priority".

In July I wrote on the subject of stopping young people smoking, and pointed to the need for research on how young people obtain cigarettes, with a view to better enforcement of or improvement of the legislation concerning the sale of cigarettes to minors. The task force recommended that such work be carried out. It also advocated the "development of school-based, smoking prevention programs, which are designed for widespread dissemination, and are amenable to ongoing scientific evaluation."

Effective programs

The task force made two other recommendations concerning programs. One was that "collaboration between program developers and reseachers" be a condition of funding of program development projects in Ontario. A dearth of such collaboration was noted, even though "those programs which have been shown scientifically to be effective have involved considerable interaction." The third recommendation for programming concerned helping smokers quit or cut back. The task force called for effective programs to be available for implementation in all Ontario communities within five years.

As well as proposing sharply increased taxes on tobacco products, the task force made four other recommendations for changes in legislation or regulation.

Three of these proposals concerned passive smoking. One was that "the Government of Ontario take legislative measures to ensure a uniform standard of protection from passive smoking in specified public places in all jurisdictions in the province." Currently, people seeking protection from other people's smoke have to rely on municipal legislation that is of doubtful validity. The task force considered the possibility of provincial legislation that would enable municipalities to restrict passive smoking effectively and without risk of challenge in the courts, but opted for province-wide restrictions largely because they might be "the only feasible means of protection in some areas of the province." A second recommendation advocated legislated restrictions upon smoking in two private areas that were considered to deserve special attention, namely nursery and daycare centres, and patient areas in hospitals. A third recommendation concerned smoking in the workplace. It was that the Ontario government "specifically provide non-smoking employees the right by law to apply for and receive, without prejudice, relief from exposure to second-hand smoke."

The final recommendation for legislation called for a Canada-wide ban on the promotion and advertising of tobacco. I have previously argued against such action (**The Journal**, Nov, 1979). My position has not changed.

As well as the recommendations for research on "less hazardous" uses of tobacco and on how smoking minors get their cigarettes, there was a call in the report for "studies designed to increase understanding of factors affecting smoking." This sounds like no more than a convenient catch-all for any research that is not otherwise covered. In reality it is the core of the problem. Exactly how is it, for example, that quitting smoking is supposed to be so difficult, and yet each year millions of people do it permanently, without the slightest help?

Resource centre

The task force's final recommendation concerned the establishment of a resource centre for smoking and health "to provide essential coordination . . . to ensure the development, dissemination, and implementation of effective smoking measures." This was the other of the two recommendations that, for the task force, "stood out" — along with the call for higher cigarette prices. This was also one of two of the task force's recommendations that did not meet with the approval of the Health Research and Development Committee of the Ontario Council of Health, to which the task force reported. Apparently the committee believed that such a centre might be an expensive duplication of existing facilities.

The other recommendation that did not find favor with the committee was the one concerning "less hazardous" uses of tobacco. The committee seemed to be of the view that a Council of Health should not be advocating research that might lead to the continuation of smoking.

As it happened, the Ontario Council of Health, when it considered the report, advocated nothing except the report's distribution. It simply transmitted the report to the Minister of Health, noting the concerns raised by its committee. The Minister endorsed the wide distribution of the report for comment.

No advocates

Thus the ownership of the report has become obscure. The task force that generated it has been wound up. No-one has the responsibility of arguing for the strong positions taken in the report. Consequently, a likely fate of the report will be a dusty shelf in the Ministy of Health, and a footnote to an unread medical history of the twentieth century.

If you would like a copy of the report write to Judy Wu at the Ontario Council of Health, 700 Bay Street, 14th Floor, Toronto, Ontario M5G 1Z6.

NEWS

All Norway talked about sober Saturday night

By Lynn Payer

MUNICH — A Norwegian campaign to get the populace to put down their '11th-hour' drinks on a certain day became the most popular topic of conversation in Norway during autumn 1981.

While the campaign wasn't ultimately successful in getting everybody to stop drinking at 11 pm on Sat, Nov 14, 1981, the drive was noticed by 83% of the population, received about 1.24 km (¾ miles) of newspaper column space, and provoked considerable public discussion about drinking.

Total alcohol consumption in Norway declined in 1981, with wine and spirits dropping by 14%, and beer by 7%.

"This was probably due to rising prices and a tighter budget," Ragnar Waahlberg, of the Norwegian Directorate of Alcohol and Drug Problems, said here at the 28th International Institute on the Prevention and Treatment of Alcoholism.

However, added Mr Waahlberg, "it's possible that the campaign (could have) provided people with an argument for drinking less in general."

Alcohol consumption did not rise between Sept and Dec, 1981. "We have no figures from the previous year to show that the level of alcohol consumption rose from Sept to Dec, but most people believe this to be the case," Mr Waahlberg said.

The campaign was based both on Norwegian drinking habits and public attitudes toward alcohol, he said. In contrast to drinking patterns found on the Continent, most Norwegians do their drinking on Saturdays either at home, or at parties. "An average party may include pre-party drinks, aperitifs, wine or beer with dinner, brandy with coffee, and one or two beers or cocktails an hour from 11 pm on," Mr Waahlberg said.

Most Norwegians have a primarily positive image of alcohol, he said, and tend quickly to forget negative experiences such as hangovers, etc.

However, "new facts" suggesting the pleasant experiences associated with drinking are caused not by alcohol itself, but by a social learning process — "the characteristics which we attribute to alcohol are in general placebo effects" — have received considerable attention in the Norwegian mass media in the past year.

"It is the experience, the mood, the status people want to retain, not the alcohol itself," Mr Waahlberg said. "The problem is that people are convinced it is the alcohol which creates these feelings."

The campaign was launched with advertisements in major publications and posters in every grocery and liquor store in the country. Typical posters showed Norwegian celebrities saying they would not drink after 11 pm on the target date.

However, the poster that attracted the most attention borrowed a slogan from Shakespeare's *Macbeth*: "It (drink) provokes the desire, but it takes away the performance." The directorate received many requests for this poster, Mr Waahlberg said, the majority of them from women.

In addition to press coverage, which "graduated from mild astonishment to positive attitudes toward the campaign a few days before Nov 14," about four hours of broadcasting time, all positive, were devoted to the campaign.

Of those interviewed three weeks following the campaign, 70% said they had not indulged in alcohol on the target Saturday at all, 7% stopped drinking before 11 pm, 11% continued drinking, and 12% could not remember.

Norwegian poster attracted attention in 11th-hour abstinence campaign.

Swedes drive clear of alcohol but their passengers overdo it

MUNICH — Strict drunk-driving laws have made Swedish drivers among the most sober in the world, a Stockholm forensic pathologist said here.

Roadside screening between 1976 and 1979 found 99.98% of drivers with blood alcohol levels below the legal limit of 0.05%, Milan Valverius told the 28th International Institute on the Prevention and Treatment of Alcoholism here.

In traffic accidents where blood alcohol was controlled, 96.87% of the drivers were found to be sober, and in other traffic offences, such as speeding and running red lights, 95% of those checked for blood alcohol were below the legal limit.

The one exception found by Dr Valverius was single traffic accidents with a fatal outcome, where 46% of drivers had blood alcohol levels above 0.05%.

"From these figures we have to assume that the drivers in single fatal accidents are a special group with peculiar characteristics of high blood and urine alcohol levels," he said. Head-on collisions between two cars found only 7% of the drivers intoxicated, he added.

Interestingly, nearly all figures showed a higher level of passenger intoxication than of driver intoxication.

Renewed fervor fails to alter grim DWI picture

By Betty Lou Lee

HAMILTON — The acronyms and players may have changed, but the current game of erasing drunk driving is the same, and the score probably won't be much different than it has ever been.

That's the rather pessimistic assessment of Herb Simpson, a psychologist who is executive director of the Ottawa-based Traffic Injury Research Foundation of Canada, a non-profit agency.

"There is no shortage of solutions, but there is a shortage of those that work . . . Everything has been tried, with no measurable impact on the alcohol-crash problem," he told the 23rd annual Institute on Addiction Studies here.

"We're now in a period of concern, with groups such as (the United States) Mothers Against Drunk Driving, and US President Ronald Reagan's special committee . . . There's a lot of emotional fervor, conviction, and commitment to stamp out drunk driving. But the same thing happened five, 10, 20 years ago . . . I don't see much light at the end of the tunnel." (**The Journal**, Feb, May).

Dr Simpson said it is politically popular to condemn the drunk driver as a sick deviant who should be locked up, "as long as you don't interfere with the rest of us who haven't been caught yet.

"The drinking driver is all kinds of people, not just the killer drunk. People like you and I enter into the drinking driver state from time to time, maybe only once or twice a year. As Pogo said, 'We have met the enemy and he is us.' "

He said the consensus of 25 experts from around the world who met last year to identify initiatives for the future was that any new drunk-driving prevention program must be an explicit, long-term commitment with a detailed, implementable, long-range strategic plan.

"Can everyone involved evolve into the network required to develop and implement a major, coordinated program? I doubt it.

"We could develop a strategic plan, but I don't know if there is the social and political will to implement it. There are too many vested interests and territories."

Some believe that tough drink-drive penalties are a strong deterrent, but there is no evidence of it, Dr Simpson said. In Sweden, for example, where jail is mandatory, 4,000 drivers were incarcerated last year. "They were lined up to get in and serve their sentences."

The real risk of getting caught for impaired driving is one chance in 1,000 to 2,000, and it would take a 20-fold increase in enforcement to increase the likelihood of detection, apprehension, and conviction, he said.

At that level, there would likely be complaints about a "police state" because of increased visibility of law officers.

Dr Simpson said young drivers are the least likely to be drinking, and to be drinking to excess, but they are the most likely to crash if they have been drinking.

Drivers beyond age 25 are the most likely to be drinking, and the least likely to crash if they've been drinking.

But the "weird network" of enforcement is designed to catch this latter group with the lower risk of having an accident. The more experienced drivers, to compensate for alcohol, give signals to police by driving slowly, or opening the window in inappropriate weather.

Dr Simpson said there is "precious little information" about the role of drugs other than alcohol in vehicle accidents.

An Ontario study of all pedestrians and drivers killed in 1978-79 showed 26% had some detectable level of another drug, but there was no way of knowing if they were impaired by these drugs, or if they contributed to the accident.

Post-mortem examinations tested for 90 drugs, and 30 were found. Cannabinoids were the commonest, mostly among young males, followed by salicylates and diazepam (mostly in older women).

Of the 45 people with detectable cannabinoids, 69% were also positive for alcohol, and 2% for other drugs, so it isn't possible to infer what role cannabis had in the accidents, he said.

FEATURES

If I was doing drugs I probably wouldn't perform like this
-Wayne Gretzky

Canada's hockey stars shoot anti-drug appeals at youth

By Mark Kearney

TORONTO — Wayne Gretzky of the National Hockey League's (NHL) Edmonton Oilers, and Paul Reinhart of the Calgary Flames, walk down a corridor in a hockey arena. Off to the side in the shadows is a young boy apparently smoking marijuana.

"If we were doing drugs," the two players say, "we probably wouldn't perform like this." The two then skate onto the ice and show some of the skills that delight hockey fans everywhere.

"Believe me, we all have the choice," Mr Gretzky, the NHL's leading scorer, concludes.

This 30-second television commercial, produced for national distribution in cooperation with the Royal Canadian Mounted Police (RCMP), was shown during last season's playoffs; it may become a familiar fixture on television screens this winter.

The commercial is the RCMP's first attempt via mass media at preventing drug abuse, says Corporal Ron Lewis of the drug enforcement branch, Ottawa.

"It's not a 'don't use drugs' message. We're basically aiming it at young people from 12, to say, 30. But it can apply to anybody."

RCMP and NHL officials say the commercials haven't been running long enough to determine their effectiveness, but they believe Wayne Gretzky's involvement will bring positive results.

Mike Griffin, a director of information at the NHL, says response to the commercial has been enthusiastic. He believes it not only gets the message across to kids, but also to parents who have children considering drug use.

"If there's one kid who idolizes a hockey player, who is on the verge of taking drugs, or is into drugs, and is waylaid by that commercial, then it's worth it," he says.

Cpl Lewis says the RCMP decided to work with the NHL because of hockey's popularity throughout Canada. Réjean Houle of the Montreal Canadiens, who has done other work for the RCMP, suggested the commercials because he believed he and his fellow athletes could have an impact on Canadian youngsters.

Mr Houle and Marc Tardif of the Quebec Nordiques appear in a French language version of the commercial.

Cpl Lewis says he would like to see baseball and football players involved in similar anti-drug campaigns.

Athletes have appeared in anti-drug commercials since the mid-1970s when professional basketball players in the United States talked about getting their "highs" on the court rather than from drugs.

These days, however, anti-drug commercials using athletes carry with them added significance. The past year has not been a good one for pro sports; publicity surrounding athletes' use of drugs has been unprecedented.

Some National Football League (NFL) players in the United States, notably Don Reese, formerly with the New Orleans Saints, have admitted using drugs such as cocaine.

Nevertheless, the NFL has no plans for any anti-drug commercials similar to the joint venture by the RCMP and the NHL.

Jim Heffernan, New York-based director of public relations for the NFL, told **The Journal** the league already has a medical assistance program for any players who may have a problem. There have also been anti- drug and alcohol commercials in the past.

He agrees, however, this year's publicity hasn't been good for the league.

"I think it (the game) has been hurt somewhat," Mr Heffernan says. "But the individuals are hurt more by drugs than the game is."

The Canadian Football League (CFL) also has no plans for anti-drug commercials, says Commissioner Jake Gaudaur. That's partly because he and other officials and players don't see drug abuse as a serious problem here.

However, both Mr Gaudaur and John Agro, senior legal counsel for the CFL Players Association, like the idea of getting involved with the RCMP on an anti-drug commercial. In the meantime, the CFL, through the Canadian Amateur Football Association, already distributes kits discussing the hazards of drug abuse to younger, aspiring players.

Mr Gaudaur and Mr Agro agree some players have probably tried or abused drugs, but they don't believe use is widespread enough to warrant any counselling or study of the problem.

One thing that prevents too many players here from getting into serious trouble is that CFL salaries usually aren't high enough to support a drug habit, and drugs are more difficult to obtain here than in the US, says Mr Agro.

But there are "so many people getting into that crap, and ballplayers are no different than the rest of society."

Workers must seek out the elderly alcoholic

By Betty Lou Lee

HAMILTON — Traditional alcoholism treatment programs have little to offer elderly alcoholics, says an Addiction Research Foundation physician.

Their denial of alcoholism is so extreme they will not become involved in any program in which they must acknowledge a problem and express a desire to change, and they won't accept the idea of total abstinence.

They may also have trouble with discussion of feelings as their generation didn't talk much about emotions. Their chronic medical problems may also prevent involvement in programs outside the home.

Sally Saunders, speaking at the 23rd annual Institute on Addiction Studies here, warned that progress is slow and takes patience.

Dr Saunders has been involved in treatment of alcoholics aged 60 and older for about 10 years, since a Toronto home for the aged sought help in dealing with patients who were verbally or physically abusive when drinking.

She found alcoholism was a major problem for 5% to 10% of residents in such Toronto homes. Common features among many of the drinkers were denial, severe isolation (often brought on by their behavior), poor communication skills when sober, no interests or activities, and depression and boredom.

She designed a program in which one staff member worked with eight patients, helping them to socialize and communicate, and trying to find interests that appealed to them.

They were told if they became abusive and disruptive while drinking, their bottle would be taken away and kept until they were sober. They were not told they could not drink.

Dr Saunders said alcoholism among the elderly is probably about the same 5% as it is in the general population, but it is more successfully hidden by the drinkers and their families.

"It's hard to diagnose unless you actually see them drinking, because many of the symptoms are the same as those experienced by the non-drinking elderly: loss of memory, confusion, depression, malnutrition, increased chronic medical problems, unsteadiness, accidents, loss of friends, and increased social isolation."

She divides them into three basic groups: those who have been drinking heavily for years (two-thirds of elderly alcoholics); those who start late in life because they find it hard to cope with the stresses of aging; and those who got through a crisis in the past by heavy drinking, and are using alcohol again to get through a crisis.

Dr Saunders found that in the community, elderly alcoholics had all the same features as those in homes for the aged, as well as misuse of a host of medications for various medical conditions, malnutrition, loss of homemaking skills, and financial, marital, housing, and family problems.

It is crucial that the person trying to help go to them, Dr Saunders said. Also it must be made clear that when helpers go, there should be no request for abstinence. Development of rapport and trust is an essential first step, and an extensive medical and psycho-social assessment is needed.

"You have to realize that denial of the problem is more extreme in the aged. Many were brought up in a society where not only alcoholism, but sometimes drinking itself, was a sin and morally wrong.

"Don't ignore the drinking, always spend some time on it, and let them know you are concerned about them. But, emphasize a problem they recognize, such as a medical one, or housing.

"Make good use of any crisis, such as fractures or burns, so it's harder for them to say they don't have a problem . . . Sometimes you can never break through the denial, and you don't need to. You can still get improvement."

Goals are critical, but at the start they should be small and specific, with a good chance of success, she said. For someone who hasn't been out of an apartment for six months, it can be something as simple as a walk around a garden. But it must be something that makes sense to the alcoholic, and valid praise for even the smallest completed goal is critical.

Programs should include home supports such as visiting therapists, homemakers, and Meals on Wheels, as well as leisure-time possibilities such as volunteer services, church, senior citizens, and specific activity groups.

'Many seniors were brought up in a society where drinking itself was a sin.'

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The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Prominent Afro-Americans begged for anti-drug help

The article, Insidious drug messages bombarding US youths (**The Journal**, Aug), was quite interesting, and I must say I totally agree with the comments. Drugs are not to be lauded. They are dangerous, and only fools use and abuse them.

As an Afro-American, however, I have noticed that the article used examples of Richard Pryor (whom I never admired), and members of the Jamaican Rastafarian Cult as typical drug users and abusers. Get off the Afro-American backs. Couldn't you have mentioned the White House drug abusers?

Couldn't you have mentioned the 'Belushi' types (Ed's note: See **The Journal**, July), and the millions of wealthy, Anglo-Saxon suppliers and users who are the real killers of innocent children. Come on, be fair.

It is time for Americans to be hoisted by their own petard at any rate. For many years, Afro-American leaders, men such as Malcolm X, had begged on their knees for an end to the "insidious drug problem bombarding Afro-American youth in the city ghettos," but to no avail. Who cared?

Over the years many — from outstanding artists, such as Billie Holiday to innocent six-year-olds in Harlem — succumbed to the deadly drugs brought in by white Americans in their expensive planes and yachts. As long as the problem was not affecting them, the gentry, who cared? But now, it is too late. The epidemic will spread and there is no stopping it.

If white America had helped the poor kids of the ghettos, and they could have, the problem would not have spread to the White House, or the million-dollar shooting galleries of Hollywood.

What a disgrace it would be to give a national holiday to drug user (Elvis) Presley, as some people are asking, and not Dr Martin Luther King, a real king of humanity. Blaming us does not help.

Peter L. Ross
New York, NY

Glue sniffing question

In the May issue of The Journal, **there was an article, Irreversible brain damage revealed in people sniffing toluene.**

Polysar produces toluene in one of our processes and would very much like to see a copy of the study done by the Addiction Research Foundation if possible.

Max Oake
Industrial Hygiene Dept
Polysar Limited
Sarnia, Ont

Reader recommends TJ

I have read **The Journal** over the years and I find it useful and comprehensive. The information comprises a wide range of various addictive conditions (drugs, alcohol, tobacco, etc), harmful effects of these, reasons, and suggestions for treatment and cure. Also, the reports on research in the field in various countries make useful and interesting reading.

I have recommended **The Journal** also to two younger specialists (psychopharmacology, psychiatry) lecturing on related subjects at the department of pharmacology of our university.

Aimo Pekkarinen, DM
Professor of Pharmacology
Institute of Biomedicine
University of Turku
Turku, Finland


Robert Solomon


Terri Etherington


Karin Maltby

New appointments

The Journal is pleased to announce the appointments of Karin Maltby as Contributing Editor (Toronto); Terri Etherington as Production Editor; and Robert Solomon as Consultant on Law.

Ms Maltby joined **The Journal** in 1975 as Editorial Assistant, was promoted to Production Editor in 1976, and, following a year's absence in 1981, resumed duties as Acting Production Editor until her appointment in August as a Contributing Editor.

Ms Etherington has had several years of experience on both editorial and production aspects of newspapers. A founding editor of *Lindsay This Week*, she was recently involved in planning and designing a new communications package, including two weekly newspapers for Victoria County, Ont. She holds a Diploma in Journalism and a BA from the University of Western Ontario.

Mr Solomon is professor of law, faculty of law at the University of Western Ontario. He recently co-authored a major piece on the Canadian Constitution for **The Journal**. The second of this two-part series appears on The Back Page this month.

FEATURE

EAPs for drug users have 'finesse of camel'

By Harvey McConnell

WASHINGTON — Drug use and abuse among employees is something most directors of employee assistance programs (EAPs) are mystified about and do not know how to deal with.

The problems extend from identification of drug users, through avoiding stereotypes, to the legal ramifications of urine testing. There are no easy answers.

This was the consensus of three panelists at the annual conference here of the Alcohol and Drug Problems Association of North America: Brenda Blair, United States department of health and human services in Chicago; John McVernon, executive vice president of the National Association on Drug Abuse Problems, New York; and Lee Dogoloff, executive director of the American Council on Marijuana.

Ms Blair pointed out that denial is even stronger among drug users than alcoholics. "If people don't like to tell you they drink, they are even less likely to tell you how much they use drugs, especially if they are illegal drugs. And if they use legal drugs then they don't think anything is wrong."

At the same time, "when you talk about the drug problem, many people don't see that prescription drugs are part of the problem, and that in particular combinations with alcohol, they can be addictive."

Another problem, in the field itself, is that definitions of drug use differ "and we don't have a united-front language to use to explain to industry that this is the type of problem they should be looking for. We don't even know how big the problem is."

About the difficulty of identifying the employee with a problem, Ms Blair said: "We have traditionally used job performance as the model for EAPs. The question that comes up again and again is, are there different indicators for the different types of drugs?

"If I asked what are the indicators for alcohol problems, one would probably point out the Monday and Friday absences, long lunches, changes in mood between morning and afternoon. These are the sorts of things you have in the back of your mind if you have been around alcoholics and EAPs a lot.

"I have asked people in the drug field what kinds of indicators there are, and I have found job performance indicators don't seem the same.

"They said people can become very dependent, they run around and ask people for a lot of help, and they are depressed a lot, but suddenly they can become very giggly and hilarious. The list is different for different kinds of drugs."

Urine test screening has been widely suggested (**The Journal**, July), "but the questions here are what are the employers' rights, the employees' rights, what about privacy? It is a very controversial and a highly important set of questions."

Even if a person is found to have a drug problem managers are often reluctant to refer them. "We find this even more than their reluctance to deal with the alcohol problem.

"They may fear 'the drug problem' and have images of what it is and find it a fearful situation.

"They are operating from a narrow stereotype of the drug user. They don't see that the person sitting right next to them with tranquillizers is a person with a problem, as well as the person who smokes marijuana and uses mood-enhancing drugs. It's simply that supervisors don't have the education about drug problems that they have about alcohol problems."

Dealing with drug problems involves legal issues. Management is often afraid of drug-related crime. Some drug use is criminal, and some drug habits are supported by thefts, and managers fear loss of supplies and cash.

"It is very different from dealing with the alcoholic who is everybody's buddy. Here we have a criminal in the workplace possibly stealing from us."

There is the concern that while marijuana smoking may not affect the job performance of some employees, it is still an illegal act in the buildings and on the grounds of the employer, and the company worries about its legal liability.

Ms Blair said the thicket gets denser: "There is also the question of search and seizure. If I open your desk to grab a pencil and find a nickel bag of marijuana, what is my obligation as a manager? Do I pick it up? Do I turn you in? What if it turns out to be oregano you were taking home to put in your Italian meatballs? We just don't know."

There is also the question of confidential information vs an obligation to report and refer illegal activities.

"There is a whole realm of legal issues that complicate the EAP and drug use, and they may be one reason we are not reaching drug cases."

Even when drug cases are referred to treatment there can be problems. Many treatment programs are street-oriented and deal mainly with people who have never had jobs. Some counsellors have never had jobs, except as counsellors.

Ms Blair said in one case she referred an employee to a program somewhat street-oriented. "The employee had a $20,000-a-year, white-collar job, and he was very bored and very frustrated. Dealing with his job was part of what was necessary for his rehabilitation.

"The counsellor, who was probably making $9,000 or $10,000, just couldn't deal with it. 'My God, man, what's the matter with you.' He just couldn't deal with another perspective."

Reverend John McVernon said social service prevention issues have always been linked closely with social control, and people accept preventive interventions which are highly selective.

He said marijuana use is widespread in both the electronics industry and the financial industry, and it is spotted quickly because there are stringent quality-control procedures.

At the end of the day, tests can be run on electronic control boards and supervisors can find that the work of people they suspect may be using marijuana is defective.

Father McVernon said the director of a cosmetics firm found most employees using drugs wandered around the work place, delayed completing tasks, and were more irritable than other workers.

Workers on drugs never look like workers abusing alcohol, he said. Nor do they look like street users or reach the point where they are completely dysfunctional.

Marijuana use widespread in electronics, finance industries.

'If people don't like to tell you they drink, they are even less likely to tell you they use drugs, especially if they are illegal drugs.'

Many are found to respond positively to good information on how the drugs they are taking affect them and how the drugs may interact with alcohol or other drugs. Practical counselling in how to cope without drugs is very useful.

The cocaine user is a special case, especially if the employee is using heavily. "The real danger is cocaine corruption," Father McVernon said.

He said the financial world has seen large-scale corruption, especially among employees dealing in overnight money markets and in situations where prices are always changing. "We find people who are into cocaine deeply are giving the best rate to the firm that is offering them a cocaine kickback."

In a special category are drug users who started using drugs in the 1960s, used occasionally as they got older, and now, in their late 30s, have come up against reality: death of a parent, divorce, realization that their dreams of success may not be met.

"Just as social drinking at that point for many people becomes alcoholic drinking, so recreational drug use at that point becomes destructive drug use," Father McVernon said.

Another drug-related problem in the workplace is drug use not by the employee, but by a son or daughter.

"These people are physically present (at work), but their mind and heart are somewhere else. They are appreciably and noticeably disabled in their functions at the work site because of worry about their son or daughter using drugs," Father McVernon added.

Many firms are responding to this problem by teaching the workers about drug use; the parents' movement has also provided momentum in communities by helping young people.

He said that it is much easier for him, as a priest, to see sin than it is for a psychiatrist to see sin. Although he is not a recovering alcoholic, many people working in EAPs are.

"We all see the things we are trained to look for, and the recovering alcoholic sees alcoholism."

Many employee assistance interveners are not going to find a drug problem when it might, in fact, be sitting across the desk from them, he said.

Another stumbling block is that drug treatment programs "are run with the finesse of a camel." Good programs for drug abusers hardly exist.

The EAP personnel have to retool their thinking "and adjust our programs to meet the needs of the contemporary client," said Father McVernon.

Mr Dogoloff said there is no question about what should be done when a person on the job is found to be using illegal drugs.

"In the work setting, it is not an issue for the employer to deal with at all but rather for the criminal justice system. Whatever the police decide to do, it is critically important that the manager or supervisor call in the authorities.

"This gets the point across in the workplace that this is unacceptable behavior. And if the manager or supervisor goes on and doesn't take quick action, they are as much as condoning the behavior and are not giving clear signals.

"The majority of drug users will change if they realize that it is not acceptable to use illicit drugs in the workplace."

Dogoloff: Drug use unacceptable in the workplace.

Blair: Management is often afraid.

McVernon: We see things we are trained to look for.

NEWS

Treated addicts do better work

HAMILTON — Initial results of a three-year study of Minnesotans treated for chemical abuse show a significant improvement in vocational functioning, less legal involvement, and fewer medical admissions.

About 4,500 patients were treated for dependency in six hospitals in the Minneapolis-St Paul area in 1980, at a total cost of $9.5 million.

About 1,000 have been followed for at least a year, and the economic recovery is estimated at $3.25 million.

The study is being conducted at the Chemical Abuse/Addiction Treatment Outcome Registry at the St Paul Ramsey Hospital Medical Education and Research Foundation in St Paul.

The first-year results were presented here to the 23rd annual Institute on Addiction Studies by Reverend Philip L. Hansen, executive director of Abbott Northwestern Hospital, Minneapolis.

There wasn't a big difference between the numbers employed before treatment and a year later: 57% vs 66%. But those with job performance problems fell to 3% from 39%, and those for whom absenteeism was a problem dropped to 4% from 39%.

Ten per cent had been fired from a job in the year before treatment, 1% in the year after. Seventeen per cent were on welfare before, 5% after.

Before treatment, 17% had been arrested for a chemically related misdemeanor, and 3% for a felony. This fell to 3% and 0% respectively. There were similar reductions in arrests for offences not related to chemicals.

Medical admissions to hospital dropped to 14% from 24%; psychiatric admissions fell to 2% from 6%, and admissions to detoxification centres were reduced to 2% from 16%.

Hansen: Dual dependence.

Mr Hansen, who has been involved in addiction rehabilitation for more than 20 years, said dual dependence and changes in the male-female ratio are some of the most significant recent developments.

Women now make up 40% of the chemically dependent, and he predicts they will outnumber male alcoholics within the next decade.

At his treatment centre, 95% of women and 50% of males have dual dependence.

Newspaper licks glue challenge

LONDON — *The London Observer*, a Sunday newspaper, has been cleared of charges by readers that a recent article on glue sniffing was in fact a "how to do it" guide for young people. A couple had complained to the Press Council, a voluntary overseeing body, that the article and accompanying picture of a young person sniffing, were irresponsible.

NEWS

Solidarity and gov't competed on alcohol policy

MUNICH — A United States alcohol researcher says that the government of Poland and the workers' union, Solidarity, tried to outdo each other in taking a hard line against alcohol availability.

"Here we have an example, almost alone among industrialized countries, of a major social movement in the modern era taking up alcoholism in the way in which workers' movements would have taken up alcoholism as an issue in the 1900s, in a number of European countries," Robin Room, PhD, told the 28th International Institute on the Prevention and Treatment of Alcoholism here. (**The Journal**, April, and July/April, 1981.)

Dr Room of the University of California said Jacek Moskalewicz of the Psychoneurological Institute in Warsaw had provided him with information about Solidarity's position on alcohol.

Dr Room: "One of the first demands of Solidarity after the Gdansk strikes of Aug 1980, was for reduction in the availability of alcohol.

"Solidarity came out very strongly with a line that 'the government has been pushing alcohol on us and disorganizing our lives. It's a cheap commodity that uses up excess purchasing power when there aren't enough commodities to use up that purchasing power. We want less alcohol in this society.' "

One of the ways Solidarity and the government signaled to each other in the following months, both that they were serious in their intent and that they intended to be non-violent, Dr Room explained, was to ban use of alcohol around their various events.

"In fact, the government and Solidarity competed with each other to claim credit for having imposed the initial bans during the strike of Aug 1980."

Both sides in the struggle, Dr Room said, picked up on the issue of alcohol, both for its own sake and as a way of talking about what society may want. The church, for example, decided people who were involved in the illegal alcohol market could not be buried in church grounds (**The Journal**, July).

Stiffer penalties not always fair

Kids learn cannabis 'is no good'

TORONTO — Most teenagers use marijuana in such moderation that it's not a problem to them or anyone else, says a Toronto lawyer.

And Ed Schofield believes the problem is diminishing.

"The crest of heavy use seems lower, based on my volume of business," he told delegates to the Council On Drug Abuse (CODA) conference here. "And I think most of the kids learn that abuse is no good."

Mr Schofield compares teenagers' use of marijuana today with their counterparts' use of alcohol in the 1950s and early 60s.

He says the volume of users is still high, but he doesn't believe stiffer court penalties will necessarily solve the problem. There are no moves toward decriminalization, but judges are unlikely to impose a harsh penalty for a first offence, he says.

Most first offenders are given a conditional or unconditional discharge and that is often enough to keep them out of court again, he says.

Mr Schofield says stiffer penalties may not be fair in many cases. All too frequently people who are simple users of marijuana are treated as if they are traffickers.

NEWS

Gitlow suggests three part alcoholism design

By Lucy Barry Robe

VALLEY FORGE, PA — Stanley E. Gitlow, who coined the term "sedativism" years ago, believes he may have found a design, or rubric, for the disease of alcoholism.

"The design has three elements," he told **The Journal** here at the National Conference on Alcoholism and the Family. "To be an alcoholic, you need all three."

Stimulus Augmenters

Alcoholics' perceptions appear to be more acute, and their appetites (ie need of relief from something) are greater than are those of non-alcoholics. (Columbia University doctoral candidate Lynn Hennecke recently found this same tendency in a study of children of alcoholics.)

Defective identification with parent of same sex

Every alcoholic in Dr Gitlow's practice of some 30 years has had a key defect in relating with the parent of the same sex.

"More than 90% of my female alcoholic patients had mothers who could not relate intimately with them. These mothers were often rather rigid people. No matter what my patients did, they felt they could not obtain love or approval from their mothers."

The rest of Dr Gitlow's female alcoholic patients had mothers who were seriously incapacitated, absent, or dead, he says.

As for men, "about three-quarters of my male alcoholic patients had fathers who were alcoholic, schizophrenic, absent due to divorce or death, tyrannical, or so taciturn they were incapable of relating with their sons," said Dr Gitlow.

"Although the other one-quarter had fathers who did relate to their sons, these fathers failed their sons by deficient dealings with mothers (wives) who were tyrannical, overwhelming, and dominant."

All of his alcoholic patients grew up distancing people, isolating, and relating emotionally with difficulty. Dr Gitlow and Ms Hennecke term this *anomie* or rootlessness.

"Appetite needs are normally met by a damping mechanism, which comes from satisfactory interpersonal relating," explained Dr Gitlow. When a boy or girl cannot relate effectively to the parent of the same sex, "the normal mechanism for damping down need is unavailable."

His patients' relationships with parents of the opposite sex appear to be unimportant to the state of anomie.

Palliative power of alcohol

Within an alcohol-using society, sooner or later a person discovers that alcohol either allows him or her to apparently relate to others, or relieves him or her of the sense of need, "now he or she believes that total relief from problems can be found via use of this one drug."

With these three elements, alcoholism can commence, says Dr Gitlow.

Although alcohol lowers an alcoholic's stimulus augmentation, Dr Gitlow says people with normal stimuli perception have no reduction when they drink alcohol.

AUSTIN, TX — Mothers-to-be were warned of the dangers of drinking during pregnancy by Mrs America 1982 as she kicked off the Texas fetal alcohol syndrome (FAS) prevention campaign here. Rhonda McGeeney, who has been enlisted to help publicize the FAS message commented, "Remember that a pregnant woman never drinks alone." The 29-year-old mother of two and step-mother of three says her children are healthy but adds she was never advised not to drink while pregnant. The campaign is sponsored by the United States National Institute on Alcohol Abuse and Alcoholism.

BC changes rules for beer, wine ads

VICTORIA, BC — British Columbia's Consumer and Corporate Affairs Minister, Peter Hyndman, has announced new rules for alcohol advertising that will permit beer and wine commercials to be carried on television and radio.

The new policy will also be financially advantageous for professional sports stadiums, such as Vancouver's BC Place which is currently under construction, allowing advertising of beer and wine on electronic scoreboards equipped with full-color instant replay.

In addition, BC newspapers, previously restricted to black-and-white liquor advertising only, will be permitted to run full-color ads, with their size increased as well, from one-eighth of a page to one-half a page.

A new requirement for all liquor advertising is that a "reasonable proportion" of content must educate consumers about the dangers of alcohol abuse. However, what constitutes a "reasonable proportion" has not been specified.

Mr Hyndman defended the policy change at a news conference with the explanation that it was necessary to modernize the rules to counter the estimated $5.1 million in revenue lost by the BC broadcasting industry in the past year because of the radio and TV ban on liquor advertising.

In 1970, the BC government spent $2 million on alcoholism treatment programs and took in $61.5 million in alcohol sales revenues. Now, the government expects to take in $365 million with about 5% or $18 million earmarked for alcoholism treatment.

NEWS

Local groups can have real impact on prevention

Public should take interest in liquor licensing system

VALLEY FORGE, PA — People concerned about "drunk drivers, accidents, excessive drinking by young people, and other ravages that stem from bar drinking," should take an interest in the system of licensing liquor establishments, and not just leave it to governments, says James M. Schaefer, PhD.

Dr Schaefer told the National Conference on Alcohol and the Family here that any citizen can confront the operator of a bar, tavern, or other drinking establishment, and a particularly opportune time to do it is when the liquor licence is up for renewal.

"I'd like to see every bar produce hard evidence that its liquor licence is not damaging the health or welfare of the community," said Dr Schaefer, director of the Office of Alcohol and Other Drug Abuse Programming at the University of Minnesota, Minneapolis.

Dr Schaefer, who is known in the field for his analyses of bar-room variables that affect alcohol intake (**The Journal**, July, 1980), suggested counties or cities could "raise the annual liquor licence fee by 25% with a payback clause for compliance with alcohol abuse awareness."

For example, he said, if the annual fee is $5,000, a bar operator would have to pay $6,250 for renewal. Six months later, the $1,250 could be recovered if the bar had complied with a specific number of the following suggested items:

- Install a breath testing machine on the premises for voluntary use, or enforced use by management which could refuse to sell drinks to an intoxicated customer, or possibly refuse to let an intoxicated customer drive home.
- Post names of local alcoholism treatment services, educate bartenders about local detoxification facilities, have phone numbers handy, and post a map showing treatment centres and DWI (driving-while-intoxicated) facilities.
- Display blood alcohol level chart prominently.
- Offer non-salty, non-greasy, free snacks (such as raw vegetables, lean meats, wheat crackers).
- Offer free taxi rides home to intoxicated customers.
- Train all staff on alcoholism crisis and prevention.
- Post or publish material on responsible use of alcohol.
- Purchase "dram shop" insurance — special liability insurance now required in 22 states in the United States whereby an individual can sue the bartender and property owner for serving an intoxicated person if there is an accident. This gets insurance companies involved in assessing risk; they will charge high premiums to high-risk bars.
- Increase availability and prominence of non-alcoholic drinks and include soft drinks in "two-for-one happy hours."
- Show annual reduction of public safety (police) calls for trouble in establishment.
- Show increased food sales from previous year.
- Show per capita reduction in alcoholic drink sales.

Liquor licences are renewed annually by city or town councils in the US. Only sometimes is a public hearing involved.

Dr Schaefer told **The Journal** that a citizen who goes to local government and presents a plan such as this one can be heard. Some of his suggestions were recently accepted in Plymouth, Mn, and he believes more will follow.

"If everyone all over the US went to their local governments when local liquor licences are up for renewal, we'd have some real impact on prevention and education," he said.

NEWS

Butt color intensity would match tar/nicotine ratings

Cigarette packs need a color code device

By Austin Rand

TORONTO — Cigarette packages should carry a color code indicating butt color at different intensities of tar/nicotine delivery, suggests a group of scientists led by Lynn Kozlowski of the Addiction Research Foundation here.

Given such a code, established for each make of cigarette, the smoker would be able to match up his or her butts with the appropriate point on the color code and immediately see how much tar/nicotine was coming through the filter, rather than relying on the standard yield numbers. As shown by Dr Kozlowski, (PhD), and others, these are a weak predictor of what the smoker might actually be obtaining.

Dr Kozlowski suggested in a 1981 paper that intensity of tar stains on the filter could be used by smokers as a monitoring device. Now, in a paper published in the June, 1982 issue of the *American Journal of Public Health*, he and colleagues Marilyn Pope, of the ARF, and William Rickert and Jack Robinson of LabStat Inc in Kitchener show the idea is workable and produces reliable results.

First, 12 butts were produced by machine-smoking a popular brand of Canadian cigarettes for five to 16 puffs, each two seconds long and providing 35 cc of smoke.

Next, within the following five hours, six men and five women decided, one subject at a time, where each butt fitted best on a 0 to 10 scale anchored on three color patches — a pale yellow one (set at 2), a greenish-brown one (set at 5) and a brown one (at 8).

With each butt, the subject started at one or the other extreme end of the scale, and, then, asking himself if the butt was lighter, darker, or the same color, moved along the scale until the butt seemed to be in the right place.

Dr Kozlowski told **The Journal**: "This search strategy makes it substantially easier than just saying, 'Here's a butt. Pick a color that matches it.' If someone is going to do a replication of this study, this is a point that I think should be kept in mind."

The individual subjects showed a high degree of agreement with each other about the actual color of each butt. "In terms of the color score given to any butt," Dr Kozlowski said, "the subjects clustered very tightly."

Also, there was a stong correlation between how dark the subjects, as individuals or as a group, judged a given butt to be, and how many puffs had been taken to produce that butt.

All in all, the researchers believe, the results indicate a color matching system of this kind does work.

"Actually, when I started this particular line of work," Dr Kozlowski said, "I was going to be satisfied with some rough, ordinal scale — one that would allow you to say simply that, for a given cigarette, one color is standard, one represents higher tar, and another represents lower. The experiment we've done suggests though that it is possible to get much more precision than that and actually wind up with an interval scale."

He pointed out though that there are at least two loopholes to such a color coding system.

For one thing, it can't take into account differences in inhalation. "We have improved prediction of what the smoker is getting from the cigarette but, still, if you have two smokers producing exactly the same darkness in cigarette butts, from the same cigarette, the body burden of chemicals is going to be vastly different if one inhales and the other doesn't."

Kozlowski: Pick a color.

Also, "there is one mode of smoking that sneaks by this system. The system assumes a constant filter efficiency but, in fact, filter efficiency is not as good if you take a high-velocity puff."

He said he and his colleagues are now doing research on this problem. "We want to know how wrong you can be. In other words, if you have two cigarette butts of the same cigarette and exactly the same color, how much difference will there be between one that has been smoked with high-velocity puffs and another smoked with low-velocity puffs?"

Despite the drawbacks, the researcher believes the color-matching system is a step forward.

"It needs development but I'm convinced by the consistency of the data in this study that even if it weren't refined, it would be useful. I think it's a practical contribution in an area where things really aren't very good."

NEWS

Pressuring alcoholics does work

WASHINGTON — A survey of 458 alcoholics in treatment programs in five states in the United States shows 89% entered programs because of pressure from others and not because it was their idea.

"This appears to contradict the idea that those around the alcoholic have little influence on his or her decision to enter a recovery program," says Jack Campbell, director, employee assistance program, Reynolds Metal.

Mr Campbell, in his report to the annual conference of the National Council on Alcoholism here, said past surveys of public attitudes indicated "many people believe that you can't help the alcoholic until he is ready, or until he asks for help.

"This suggests that some internal 'miracle' happens, fully detached from the world in which the alcoholic exists, that will somehow result in his voluntary act of asking for help."

Mr Campbell said that in the study a detailed questionnaire was sent to seven well-known inpatient treatment centres, three outpatient facilities, and several AA (Alcoholics Anonymous) groups. A total of 458 recovering alcoholics answered.

Mr Campbell said the questionnaire answers were subjected to a number of analyses. Most of the respondents expressed great concern about losing a family, spouse, or job before entering treatment.

NEWS

A biological marker?

Alcohol may alter thyroxine action

MUNICH — Alcoholics have low blood concentrations of the thyroxine metabolite T_3, which rises rapidly as soon as they stop drinking, Alberto Matcovich, of the Ospedale S. Filippo Neri in Rome said here.

While T_3 levels are lowered in a number of conditions, an altered ratio of T_3 to thyroxine appeared to be more specific and shows promise as a biological marker of alcoholism, Dr Matcovich said. He was addressing the 28th International Institute on the Prevention and Treatment of Alcoholism.

Dr Matcovich explained that the thyroid gland primarily produces thyroxine (T_4), which is converted into T_3 by other organs, primarily the liver. T_3 is thought to be the active form of thyroid hormone, he said.

Dr Matcovich said his findings "could lead to the hypothesis that alcohol blocks the conversion of T_4 to T_3 in the liver and other tissues as well."

Cirrhosis patients have low levels of T_3, which may reach the levels found in frank hypothyroidism. While patients with hypothyroidism have a decreased secretion of thyroid hormones, cirrhosis patients appear to have normal thyroid hormone secretion but defective conversion of T_4 to T_3.

The 37 alcoholics studied had a mean daily alcohol intake of 200 grams, mostly in the form of wine. Upon hospital admission, their therapy consisted of Vitamin B6, diazepam, and glucose solutions. Seven days later the mean value of the ratio had fallen to a level similar to that of a group of control patients.

NB takes aim at smokers

TORONTO — The New Brunswick Council on Smoking and Health will organize mini tobacco and health councils in the major cities and towns of that province with the assistance of a $20,000 federal grant.

A report on the smoking habits of school children published by National Health and Welfare in Canada in 1980 showed that the Maritime provinces, notably New Brunswick, have "the highest proportion of daily smokers" in the country.

This publication is indexed in

BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

The Journal
Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560) lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1 sold in ¼ increase

Circulation: 15,094
(Ontario, 11,580; other provinces, 815; USA, 1,979; foreign, 720). Bulk, 3,700; Media, 1,273

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents - $12 per year
U S A & Foreign Residents - $16 per year

Bulk Subscription Rates:
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Member of ccab
ISSN 0044-6203 Printed in Canada

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Sex, Booze and Blues and Those Pills You Use

Number: 513.
Subject Heading: Alcohol and the family, alcohol and sex.
Details: 15 min, 16mm, color.
Synopsis: This animated film, involving Romeo and Juliet, takes a light-hearted look at problems in sexual functioning created by alcohol abuse. At first, the couple use alcohol to feel comfortable with the opposite sex. As time progresses they rely increasingly on more and more alcohol to experience the "romantic glow." Eventually Romeo can no longer function sexually and seeks treatment.
General Evaluation: Good-very good (4.6). This contemporary and well-produced film was judged to be a good teaching aid with a length appropriate for most educational settings. General broadcast was recommended.
Recommended Use: The film would likely benefit teens (aged 15 to 18), adults, alcohol abusers, and health care professionals.

Trigger Films For Alcohol Education

Number: 514.
Subject Heading: Trigger films, youth and alcohol, alcohol and alcoholism overview.
Details: 8 min, 16mm, color.
Synopsis: Six separate vignettes of alcohol use are portrayed for the purpose of starting discussion:

- Several teenagers are drinking at a party — one is drinking pop;
- A young man tries to drink more than his buddies;
- During a celebration toast one diner attempts to refuse the wine;
- Some boys playing street basketball let a little kid join them but refuse to let him drink with them after the game;
- A boy with little to do, peers in a tavern window;
- A boy with a bottle of wine urges his friend to share it with him.

General Evaluation: Good-very good (4.6). The group judged the trigger films to be good teaching aids.
Recommended Use: They would likely benefit their intended audiences (aged eight to 18). The presence of a resource person is essential to facilitate discussion.

Alcohol and Teenagers

Number: 516.
Subject Heading: Youth and alcohol, alcohol and the family, attitudes, alcohol and alcoholism overview, trigger film.
Details: 3 filmstrips and cassettes, (12min each), color.
Synopsis: This three-part filmstrip presents a number of situations in which alcohol has become a problem for teenagers and deals with issues such as peer influence, social drinking, alcoholic parents and friends. Discussion questions are included to provoke decision-making for the viewer.
General Evaluation: Good (4.2). These contemporary and informative filmstrips were judged to be good teaching aids and likely to produce attitudes opposed to alcohol abuse.
Recommended Use: The filmstrips would likely benefit the intended audience of teenagers. The presence of a resource person is essential to facilitate discussion.

King Size

Number: 517.
Subject Heading: Smoking.
Details: 6 min, 16mm, color.
Synopsis: This animated film looks at some of the unpleasant aspects of smoking. A young boy arrives in the "Land of King Size" where he meets King Size who can blow smoke rings in the shape of animals. Believing this to be fun, the boy tries smoking, gets sick, and ends up in an ashtray. The whole land is involved with smoking and when he puts out a cigarette he is shot with a cannon loaded with cigarettes.
General Evaluation: Poor-fair (2.8). This outdated, boring, and trite film was judged to be unrealistic and lacking a clear message.
Recommended Use: The film was judged to be neither harmful nor beneficial to any audience.

Drugs: Values and Decisions

Number: 515.
Subject Heading: Drugs and youth, youth and alcohol, attitudes, communication, trigger films.
Details: 3 filmstrips and cassettes, (12 min each), color.
Synopsis: This three-part filmstrip series focuses on reasons why young people take drugs (ie peer influence, family conflict, problems in school) through the presentation of a number of case studies and discussion questions.
General Evaluation: Good-very good (4.7). These contemporary and informative film strips were judged to be good teaching aids. The discussion questions presented would be useful in decision-making regarding drug abuse and would likely produce attitudes opposed to drug abuse.
Recommended Use: The filmstrips would be beneficial to their intended audiences of teenagers (age 12 to 18) and drug users. The presence of a resource person is essential for facilitating discussions.

DEPARTMENT

New Books

by RON HALL

Currents In Alcoholism Volume VIII: Recent Advances in Research and Treatment

. . . edited by Marc Galanter

For the past six years, the National Council on Alcoholism has published this series which contains original scientific papers selected by peer review, and papers based on presentations from the organization's annual medical-scientific conference. This volume includes a number of review papers to draw a perspective on recent work in the field, and complement the original research reports. Clinical physiology, diagnosis and treatment, special populations, preclinical physiology, and reproductive effects of alcohol, are the headings for the five sections. The section dealing with special populations includes original reports on preliminary data from two national surveys; characteristics of adolescents who seek treatment for alcohol and other drug dependence; serum alcohol levels and the incidence of trauma; psychiatric diagnosis among female alcoholics; drinking patterns and preferences among heart patients; gender differences in the impact on alcoholics; and the relationship between typical companion status and consumption level in college students.

(Grune and Stratton, 111 Fifth Avenue, New York, NY 10003, 1981. 527p. $48.50. ISBN 0-8089-1458-8)

Alcohol, Society, And The State

Volume 1: A Comparative Study of Alcohol Control

. . . by Klaus Mäkëla, Robin Room, Eric Single, Pekka Sulkunen, and Brendan Walsh

Volume 2: The Social History of Control Policy in Seven Countries

. . . edited by Eric Single, Patricia Morgan, and Jan de Lint

This report of the International Study of Alcohol Control Experiences, in collaboration with the World Health Organization Regional Office for Europe, presents the results of the seven participating organizations who joined the project. In order to understand the social dynamics of the post-war increase in alcohol consumption, and to study the control measures in their historical context, the project was carried out as a series of comparative case studies. The first volume is an international discussion of the post-war experiences (1950-1975) of the seven societies — Poland, Finland, Switzerland, the Netherlands, Ireland, Ontario, and California. The first three chapters look at patterns of alcohol consumption, alcohol problems, and control systems as aspects of the same historical phenomena. The three final chapters are focused more directly on policy, discussing alternative scenarios for the future, and assessing the potentials of control measures for influencing both consumption and its adverse consequences. The second volume presents the alcohol control experiences in the seven different settings. The one overriding conclusion which can be derived from these case studies, is that specific policy recommendations are rarely, if ever, applicable to the situation prevailing in a given jurisdiction. The societies studied in these two volumes all belong to the industrialized part of the world but the analysis sheds light on genuinely international processes that are likely to have a global influence. The report also analyses the social dynamics and structural constraints of control policies, considerations essential to the design of realistic measures for strengthening the impact of public health concerns but which are not often taken into account.

(Addiction Research Foundation, Marketing Services, 33 Russell Street, Toronto, Ontario M5S 2S1, 1982. 2 vols. $50. hc. $40 pap. ISBN 0-88868-061-9 V.1 ISBN 0-88868-060-0 v.2)

Other Books

Fetal Alcohol Syndrome: Volume III: Animal Studies — Abel, Ernest L. (ed). CRC Press, Boca Raton, 1982. Animal models; statistical considerations; growth and development in animals prenatally exposed to alcohol: behavioral teratology; possible role of the parental alcohol consumption in the etiology of the fetal alcohol syndrome; genetic influences in the etiology of the FAS: effects of neonatal ethanol exposure on brain development in rats: effect of prenatal ethanol exposure on neurochemical systems. Index. 189p. $78.68.

Content and Effects of Alcohol Advertising — Atkin, Charles, and Block, Martin. Michigan State University, East Lansing, 1981. Advertising placement and alcohol consumption statistics; content analysis of alcohol advertising; field survey; self-report survey; advertising response study; experimental study. 434p.

The Clinical Treatment of Substance Abusers — Brill, Leon, Free Press, New York, 1981. Evolution of treatment and management approaches; drug classification and terminology of use; prevention; intake process; individual therapy; group therapy; family therapy; interdisciplinary collaboration; training. Appendices, indexes. 250p. $21.80.

Treatment Services for Drug Dependent Women: Volume 1 — Beschner, George M, Reed, Beth Glover, and Mondanaro, Josette (eds). US Government Printing Office, Washington, 1981. Intervention strategies; drug dependent women; intake and diagnosis; counselling process; medical services; vocational rehabilitation; family therapy approaches; childcare support services; parenting and child services. Index. 504p.

Assessing Marijuana Consequences: Selected Questionnaire Items — Huba, George, Bentler, Peter M., and Newcombe, Michael (eds). US Government Printing Office, Washington, 1981. Questionnaire items; descriptions of the marijuana consequences item-rating statistics; recommendations from a science administration perspective; drug use questionnaire short form. References. (NIDA Research Issues No 28.) 140p.

New Approaches to Treatment of Chronic Pain: A Review of Multi-Disciplinary Pain Clinics and Pain Centres — Ng, Lorenz Ky (ed). US Government Printing Office, Washington, 1981. Appendix. (NIDA Research Monograph, No 36.) 198p.

Benzodiazepines: A Review of Research Results 1980 — Szara, Stephen I., and Ludford, Jacqueline P. (eds). US Government Printing Office, Washington, 1981. Based upon papers from the Review Conference on Benzodiazepines held Sept 12, 1980 in Rockville; biochemistry; anatomical aspects; self-administration in animals and humans; dependence studies in rodents; clinical use patterns; dependence; performance effects. (NIDA Research Monograph No 33.) 101p.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Update in Psychiatry — Oct 24, Toronto, Ontario. Information: Gina Shochat, 600 Sherbourne St, #203, Toronto, ON, M4X 1W4.

Alberta Workplace '82 — People, Performance, Productivity — Oct 26-27, Lethbridge, Alberta. Information: EAP Conference, AADAC Office, Room 254, 200 - 5th Ave S, Lethbridge, AB T1J 4C7.

Early Recognition and Management of Health Problems in the Workplace — Oct 28, Nov 25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Road, Toronto, ON M4G 3Z1.

American Society of Criminology — Nov 4-6, Toronto, Ontario. Information: Harvey C. Horowitz and Associates, 10369 Currycomb Court, Columbia, Maryland 21044.

Special Delivery: Innovative Technologies for Education and Treatment — Nov 14-16, Calgary, Alberta. Information: Marge Benner, Alberta Alcoholism and Drug Abuse Commission (AADAC), 1177 - 11 Ave SW, Calgary, AB, T2R 0G5.

110th American Public Health Association Annual Meeting — Nov 14-18, Montreal, Quebec. Information: Sam Lomauro, Conventions and Exhibits Manager, American Public Health Association, 1015 15th St, NW, Washington, DC 20005.

The Management of Employee Assistance Programs — Feb 23-25, 1983, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

United States

The Benzodiazepines Today: Two Decades of Research and Clinical Experience — Oct 8-11, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, CA 94117.

6th Annual Drug and Alcohol Abuse Conference — Oct 12-14, Lancaster, Pennsylvania. Information: Carol Williams, Chief, Division of Intervention Services, Office of Drug and Alcohol Programs, 2010 N Front St, Building 3, Harrisburg, PA 17120.

6th Annual Conference of the Florida Occupational Program Committee Inc — Oct 13-15, Jacksonville, Florida. Information: Steve Serventi, Director of Employee Management Systems, PO Box 3846, Tallahassee, FL 32303.

Conference on Alcoholism Treatment Evaluation: Issues and Applications — Oct 14-15, Fort Worth, Texas. Information: Wendy Lipton, Center for Organizational Research and Evaluation Studies, Texas Christian University, PO Box 32874, Fort Worth, TX 76129.

Governor's Conference on Children of Alcoholics — Oct 14-15, New York, New York. Information: Phyllis A. Mullaney, Conference Coordinator, Governor's Conference on Children Of Alcoholics, 194 Washington Ave, Albany, NY 12210.

Basic Workshop on Chemical Dependency and the Family — Oct 18-22, Minneapolis, Minnesota. Information: Maryann Pennington, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441.

National Conference on the Treatment of Post-Vietnam Stress Syndrome — Oct 19-21, King's Mill, Ohio. Information: Diane Henry, Human Resource Initiatives, 1040 S Smithville Rd, Dayton, OH 45403.

National Safety Council — Oct 19-22, Chicago, Illinois. Information: NSC Congress Planning Department, 444 Michigan Ave, Chicago, IL 60611.

Florida Alcohol and Drug Abuse 2nd Annual Conference — Oct 20-22, Miami Beach, Florida. Information: Florida Alcohol and Drug Abuse Association, 1300 Executive Center Drive, Suite 300-302, Tallahassee, FL 32301.

Directions in Alcohol Abuse Treatment Research — Oct 20-23, Newport, Rhode Island. Information: Barbara S. McCrady, Butler Hospital, 345 Blackstone Blvd, Providence, RI 02906.

National Black Alcoholism Council, Inc, 4th Annual National Conference — Oct 21-24, San Diego, California. Information: Don Owens, NBAC National Conference Planning Committee, 4208 National Ave, San Diego, CA 92113.

1982 Postgraduate Course in Clinical Pharmacology, Drug Development and Regulation — Oct 25-Oct 29, Rochester, New York. Information: William M. Wardell, MD, Pharmacology Department, The University of Rochester, Medical Center, 601 Elmwood Ave, Rochester, NY 14642.

Impact: Adolescent Chemical Dependency: A School Program — Oct 25-29, Nov 15-19, Orange County, southern California. Information: Tim Allen, Manager of Educational Services, Problem Talk Shop, 2101 E Fourth St, Suite 185, Santa Ana, CA 92705.

Human Sexuality and Chemical Use — Oct 25-29, Minneapolis, Minnesota. Information: Betty Reynolds, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441.

American Medical Writers Association 42nd Annual Conference — Oct 26-30, Los Angeles, California. Information: American Medical Writers Association, 5272 River Rd, Suite 370, Bethesda, Maryland 20816.

2nd Annual Fall Conference on Alcoholism — Oct 27-29, Williamsburg, Virginia. Information: Craig Nuckles, Riverside Hospital Alcoholism Treatment Program, J. Clyde Morris Blvd, Newport News, VA 23601.

3rd Annual Seminar, Alcoholism in the Black Community — Oct 30, Newark, New Jersey. Information: ABC, c/o RAFT, East Orange General Hospital, 300 Central Ave, East Orange, NJ 07019.

Sexuality and Alcohol/Drug Dependence — Nov 1-2, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Training School on Alcohol and Drug Abuse — Nov 1-19, Minneapolis, Minnesota. Information: Betty Reynolds, Johnson Institute, 10700 Olson Highway, Minneapolis, MN 55441.

11th Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) — Nov 2-5, Philadelphia, PA. Information: ALMACA, 1800 N Kent St, Suite 907, Arlington, Virginia 22209.

Alcoholism: Culture and Treatment: Comparative Perspectives from Europe and America — Nov 4-6, Farmington, Connecticut. Information: Margie Meadows, Administrative Assistant, Department of Psychiatry, University of Connecticut Health Center, Farmington, CT 06032.

Alcohol, Drugs, and Aging: Development, Diagnosis, Treatment — Nov 8-9, Coatesville, Pennsylvannia. Information: Dr K. A. Druley, Chief, SATU (116A5), CVAMC, Coatesville, PA 19320.

Women In Crisis, Inc, 4th Annual Conference — Nov 10-13, New York, New York. Information: Women In Crisis, Inc, 37 Union Square West, New York, NY 10001.

An International Perspective on Substance Abuse: The Problem, Its Treatment, and Medical Education — Nov 15-19, Oakland, California. Information: Dr Charles Buchwald, Conference Coordinator, Downstate Medical Center, 450 Clarkson Ave — Box 129, Brooklyn, New York 11203.

7th Southeastern Conference on Alcohol and Drug Abuse ("SECAD") — Dec 1-5, Atlanta, Georgia. Information: Barbara D. Turner, RN, Conference Coordinator; Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Suite 170, Atlanta, GA 30342.

Intervention-Counselling Techniques — Dec 6-8, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Clinical Decision Making in Alcoholism and Drug Abuse — Dec 6-10, New York, New York. Information: Andrew J. Gordon, Smithers Alcoholism Treatment and Training Center, St Luke's-Roosevelt Hospital Center, 428 West 59th St, New York, NY 10019.

9th Winter Midwest Institute of Alcohol Studies — Jan 9-14, 1983, Kalamazoo, Michigan. Information: Margaret M. Bernhard, Division of Continuing Education, Western Michigan University, Kalamazoo, MI 49008.

Alcoholism — The Search for the Sources — Jan 19-21, 1983, Raleigh, North Carolina. Information: Sparky Carpenter, Information Specialist, PO Box 6507, Raleigh, NC 27628.

Family Dynamics of Alcohol/Drug Dependence — Feb 14-16, 1983, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

National Alcoholism Forum, Marketing the Message — Apr 14-17, 1983, Houston, Texas. Information: Louisa Macpherson, Forum Coordinator, National Council on Alcoholism 733 Third Ave, Ste 1405, New York, NY 10071.

American Medical Society on Alcoholism — Apr 14-20, 1983, Houston, Texas. Information: J. Chen See, MD, AMSA 733 3rd Ave, New York, New York 10017.

7th World Conference of Therapeutic Communities — May 8-13, 1983, Chicago, Illinois. Information: Donna Gleixner, Gateway Houses Foundation, Inc, 624 S Michigan Ave, Chicago, IL 60605.

Abroad

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

International Conference on KHAT - The Health and Socio-Economic Aspects of KHAT Use — Jan 17-21, 1983, Antananarivo, Madagascar. Information: Archer Tongue, Director, International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

NSAD 10th Biennial Summer School on Alcohol, Drugs and Chemical Dependency — Jan 26-28, 1983, Wellington, New Zealand. Information: Bursar, Barbara Mills, NSAD, PO Box 1642, Wellington, NZ.

World Conference on Alcoholism — Feb 26-Mar 6, 1983, London, England. Information: Pat Fields, Charter Medical Corp, 5780 Peachtree Dunwoody, Rd, Suite 170, Atlanta, Georgia, 30342.

7th World Congress of Psychiatry — July 11-16, 1983, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, 1983, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, 1983, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

Drugs, alcohol, and the Charter

Part two of two

*Part One of this series (***The Journal,** *Sept), set out in general terms the substantive provisions and procedural framework of Canada's new Charter of Rights and Freedoms. The focus of this article is on several specific drug- and alcohol-related issues that are likely to arise under the Charter. As has been suggested, any discussion of the Charter's impact must be viewed as speculative at this early date. It is easy enough to identify areas of probable litigation, but is far too soon to predict the ultimate resolution of these legal contests. The Charter cases that have already been decided reflect the often divergent reasoning of Canada's lower court judges. Canadians will have to wait for appellate courts, and particularly the Supreme Court of Canada, to decide a number of cases before any general principles emerge.*

By Mel Green
and
Robert Solomon

One matter that is certain to invite consideration of the Charter guarantees is the extraordinary search powers in drug cases. A police officer has far broader powers of search and seizure in even a minor drug case, such as simple possession of cannabis, than he has in a murder, rape, or other serious criminal case.

For example, the Narcotic Control Act and Food and Drugs Act authorize any officer to enter and search, day or night, any place other than a dwelling-house (home) in which he reasonably believes there is a drug, and, also, to search any occupant. Perhaps the most noteworthy aspect of this power is that an occupant must submit to a physical search in the absence of any evidence, belief, or even suspicion of wrongdoing on his part. This represents a marked departure from the established principle that an individual need only submit to a search after he has been lawfully arrested, and the arrest, to be lawful, must be based on a reasonable belief that the individual was, or is, involved in the commission of a criminal offence.

The most controversial feature of the special drug enforcement powers involves the search of homes pursuant to the authority of a writ of assistance. Generally, the police can only enter a home if they have a valid search warrant duly issued by a judge. Judicial scrutiny of the police evidence and control over the issue of the search warrant are designed to protect the sanctity of the home and the privacy of the individual. However, the Narcotic Control Act and the Food and Drugs Act provide for the issuance of writs of assistance which in essence empower their holders to enter and search any home, day or night, in which they reasonably believe there is a narcotic, and to search all the occupants.

Blanket powers

A judge of the Federal Court must issue a writ to any person who is named in the Attorney General's application. The writ gives its holder basically blanket search powers; it is not limited as to time or place, and is valid for the officer's entire career. The federal judge who issues a writ has absolutely no control of when, why, how often, or in what circumstances it is involved, regardless of any abuse that may arise. It should be pointed out that the RCMP (Royal Canadian Mounted Police) policy requires that a report be filed each time a writ is used but no drugs are seized. Even if this internal departmental review were scrupulously performed, such a procedure is a far cry from the traditional requirement that the judiciary, based upon police evidence under oath, issue a search warrant authorizing each police entry into a home.

The problem with the drug search powers is precisely that they eliminate all of these traditional safeguards. Police discretion is substituted for judicial discretion and the scope of drug searches is virtually unbridled. These powers are surely extraordinary and they will inevitably be challenged as unreasonable infringements of the Charter's search and seizure guarantees.

Similar concerns arise about the broad search and seizure powers granted police under highway traffic acts, liquor licence acts, and other provincial statutes. Prince Edward Island, for example, has recently amended its mental health legislation to give police officers the right to enter homes without warrant to apprehend people they suspect are dependent on alcohol or other drugs.

Presumption of innocence

Canadian drug legislation, like that in most western countries, includes an offence of possession of drugs for the purpose of trafficking. Trafficking itself need not have occurred to convict an accused: so long as he is found in possession of the drug — in any amount — he can be convicted of the offence of possession for the purpose of trafficking if the unlawful purpose is established. Ordinarily, of course, a burden rests on the prosecution to prove all the elements of an offence beyond a reasonable doubt. In the case of possession for the purpose of trafficking, however, once the prosecution has proven possession, the burden shifts to the accused to prove that he did not possess the drug for the purpose of trafficking.

It is this transfer of the burden of proof to the accused that may constitute an insupportable departure from the traditional presumption of innocence now entrenched in section 11(d) of the Charter. Attempts to shift the burden back to the prosecution, through reliance on the presumption of innocence recognized in the Canadian Bill of Rights, were ultimately unsuccessful. The early Charter cases, while not unanimous, have tended to uphold the constitutionality of the current law.

Parts of the impaired driving and breath analysis sections of the Criminal Code also create statutory assumptions or "deeming provisions" that appear, on their face, to conflict with the right to be presumed innocent. Similar concerns have been expressed about recent Ontario legislation which permits a police officer to suspend temporarily the driver's licence and impound the vehicle of a driver who registers a blood alcohol level of 0.05% or more on a roadside-screening or breath analysis test. While the Supreme Court of Canada has not shown much sympathy for this line of defence argument in the past, the enactment of the Charter will almost certainly compel the Court eventually to reconsider the entire issue.

Cruel and unusual

There is probably no aspect of Canada's drug laws that offends defence counsel as much as the minimum penalty of seven years imprisonment upon conviction of the offence of importing a narcotic. Because the importing law does not distinguish between amounts or types of narcotics, a person convicted of bringing a single joint of marijuana into Canada is necessarily liable to at least seven years of incarceration. While the generally fair exercise of prosecutorial discretion has precluded many potential tragedies, the question remains as to whether the mandatory penal sanction violates an accused's Charter-guaranteed right not to be subjected to any cruel and unusual treatment or punishment. Previous challenges under the Bill of Rights have proved unsuccessful.

This right may also be relied on to contest the constitutionality of provincial motor vehicle legislation which authorizes the automatic suspension of a driver's licence upon his conviction for impaired driving and breath analysis-related offences. In addition, mandatory alcohol and heroin addiction programs may be viewed as cruel and unusual "treatment" where, for example, the rational connection between the therapy and the "disease" is tenuous, or the period of confinement is indefinite or disproportionate to the underlying disorder.

Impaired driving

One area that is certain to attract considerable Charter applications is that of the federal drinking and driving legislation and its provincial counterparts. Some of the likely challenges have already been mentioned, but many others are likely to arise.

For example, does the Criminal Code provision requiring a suspected impaired driver to provide a breath sample violate his Charter-guaranteed right not to be compelled to be a witness against himself? Traditionally, this right has been restricted to testimonial evidence only; but is there now a broader privilege against self-incrimination that extends to blood and breath test results? Appellate courts are likely to rule in the negative, but the lower court opinions are now divided on the subject. Similarly, does the fact that an accused is not provided with a sample of his own breath deny, or infringe, his Charter right to a "fair hearing" where the prosecution intends to rely on its sample of his breath to convict him? English law apparently allows for an independent chemical analysis at the request of the accused, but there is no comparable Canadian provision in law or practice.

The broad powers granted the police under provincial highway traffic and liquor licence acts may also be challenged as contrary to the new Charter. In 1981, for example, Ontario enacted legislation permitting an officer to stop any vehicle at random to determine if the driver has been drinking. It may well be that these people have been "arbitrarily detained" in breach of their section 9 rights, but this is an unlikely result in light of the current case law.

Effect of breaches

Even if current legislation or enforcement practice is found to be inconsistent with Charter-guaranteed rights and freedoms, they may still be upheld as constitutionally permissible. As indicated in Part One (**The Journal**, Sept), individual liberties are subject to reasonable limitations. To use the last example, even if courts were to decide that the random stopping of drivers constituted arbitrary detention, the empowering legislation may still be upheld if the same courts decide, pursuant to section 1 of the Charter, that it represents a reasonable limit on individual freedom in light of the demonstrably justifiable effectiveness of the program in curtailing motor vehicle accidents, injuries, and death.

Conclusion

As is almost always the case when civil liberties are raised, the courts will be forced to balance the need to safeguard individual freedoms and rights against the promotion of that public good thought to underly the impugned legislation. It is this proper balancing of interests and values — rather than any mechanical application of legalistic formulae — that, it is hoped, will determine the ultimate impact of the Charter and the shape of future drug and alcohol control policies.

The answers to the Charter questions posed here and elsewhere will not be immediately forthcoming. While the media will inevitably publicize those lower court decisions that constitute a departure from judicial precedent, it must be remembered that it is the more controversial judgements that are likely to be appealed, and that it is in the appeal courts — often without publicity — that these matters will be finally decided. Dedicated Charter-watchers would do well to rein in their initial enthusiasm for specific cases lest they find themselves galloping off in a different constitutional direction than that charted by the higher courts.

Mr Green is a Toronto Lawyer with the firm of Ruby and Edwardh. Mr Solomon, a professor of law at the University of Western Ontario, is also a consultant on legal issues to The Journal.

THE BACK PAGE

Vol. 11 No. 11 2nd Class Mail Reg No. 2776 TORONTO November 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

US says it works, developing countries say it doesn't

Crop eradication debate still hot

By Karin Maltby

TORONTO — The United States will continue to encourage countries producing illicit opium and other drugs to eradicate their crops, even though several experts from developing nations say the program cannot work.

While the US has applauded limited opium crop eradication in Thailand (**The Journal**, March), Thai officials are less enthusiastic.

Major General Pow Sarasin, secretary-general, the Office of the Narcotics Control Board in Bangkok, told **The Journal** officials there are unhappy with the outcome of the project — a breakdown in delicate attempts to persuade opium-growing, hill-tribe villagers to substitute agricultural crops for the narcotic.

And, in Peru, a joint campaign of the US and Peruvian governments to burn illegal coca plantations and cocaine-processing equipment met with failure. Farmers simply began to plant coca again "as soon as the blaze went out," says Federico Raul Jeri, chairman of the Drug Addiction Committee, Ministry of the Interior, Lima

Dr Jeri told **The Journal** eradication projects "were a waste of money and a waste of time."

Meanwhile, however, US officials point to the Mexican crop eradication program as an indication of what they consider a success story in terms of reducing supply.

Gene Haislip, director, Office of Compliance and Regulatory Affairs, US Drug Enforcement Administration, told **The Journal** the jointly-financed US-Mexico project has "been quite successful in reducing the availability of heroin in the United States, so that the program seems to have worked quite well."

Mr Haislip doubts whether crop substitution programs can be successful. "In most cases, (of) which I'm aware, the substitute crop is not able to provide the income substitution in lieu of the illicit crop."

Although there are problems with crop eradication, he said, it is possible because illicit crop cultivation is "a new activity, or the expansion of an old activity, and is not an entrenched centuries-old activity as has been suggested.

"If we take the example of coca, it's fairly clear from the available evidence that the amount of coca planting and harvesting has probably increased tenfold in the last two or three years."

However, Dr Jeri, in a paper presented to an international working party here on the United Nations Single Convention on Nar-

(See — Crop — page 2)

Opium crop destruction in Mexico reduced heroin supply to US, say American officials.

New control recommendations go to UN

TORONTO — A series of recommendations aimed at improving and refining international drug controls will be presented formally to the meeting in February, 1983, in Vienna, of the United Nations Commission on Narcotic Drugs.

The recommendations were drawn up by an international expert group in a week-long meeting here in September at the Addiction Research Foundation (ARF).

The meeting — the Working Party on the Single Convention on Narcotic Drugs — was sponsored by the ARF, the UN Fund for Drug Abuse Control, and the Ministry of Health and Welfare Canada, in collaboration with the World Health Organization and the International Council on Alcohol and Addictions.

The Journal will report in an upcoming issue on the meeting, the background of the Single Convention, some of the problems surrounding it, and on the main conclusions and recommendations of the working party.

US targets producers and traffickers in five-point federal drug strategy

Reagan: time to cripple the mob.

By Harvey McConnell

WASHINGTON — Any real success in reducing substance abuse within United States society and among individuals is achieved "when those people most affected by drug and alcohol abuse are directly involved in solving their own problems."

This is the major theme of a long-awaited US federal strategy for prevention of drug abuse and drug trafficking.

Carlton Turner, PhD, director of the White House drug abuse policy office said the strategy "allows each department and agency to have a policy which will fit under the general umbrella, and, in a positive way, to reduce the flow of drugs and create a climate whereby people of this country realize the thing to do is not drugs."

President Ronald Reagan announced that 12 new regional task forces, with at least 1200 new agents and prosecutors, will broaden the fight against narcotics trafficking.

The president said: "The time has come to cripple the power of the mob in America."

Attorney General William French Smith said illegal drug sales in 1980 garnered $79 billion.

President Reagan will seek additional money for the escalated war on crime and drug trafficking as part of an amendment to his 1983 budget.

The five major elements of the administration's drug strategy are international cooperation; drug law enforcement; education and prevention; detoxification and treatment; and research.

In a summation of the international situation, the strategy concludes: "We will continue to expand and improve our own international programs, not only because of our desire to stimulate other nations to do the same, but because success in the international program is critical to reducing the supply of illicit drugs in the United States.

"An effective program to control the production, processing, and trafficking of illicit drugs overseas, as close to the source as possible, is an essential element of the administration's strategy."

In the drug-law enforcement field, much of what is outlined in the federal strategy is now being

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INSIDE

NEWS

Briefly...

Anti-Sniff tape

OTTAWA — A videotape about the effects and possible dangers of sniffing solvents will be produced by the Winnipeg (Man) Anti-Sniff Coalition using a contribution of $17,000 from Health and Welfare Canada. The Alcoholism Foundation of Manitoba has contributed $1,500 to the project.

Vodka rationing

TORONTO — A wave of organized crime, bootlegging, and moonshining has been reported in Poland following a move by the government there to ration vodka and to limit the amount of scarce grains and potatoes used in the manufacture of the drink. A report in the newspaper *Slowo Powszechne* says rationing of vodka led to the emergence of "a completely new form of crime — mass selling of alcohol outside rationing system by organized gangs." The newspaper adds health authorities in Poland are reporting a rise in poisonings from the drinking of cleaning fluid and automobile antifreeze as substitutes for vodka.

No-smoking bylaw

ORILLIA — Simcoe County's Interagency Council on Smoking and Health hopes to have a no-smoking bylaw for this city by early next year. Dr David Korn, the county's medical officer of health, says his group will make a presentation to city council warning about the dangers of sidestream or second-hand smoke. The Interagency council last year established a similar bylaw in Barrie, the county's largest city.

One-two punch

MONTE CARLO — Smoking cigarettes and drinking coffee can provide a knock-out punch to the beneficial effects of antihypertensive drugs, says a British physican. Dr Lawrence F. Ramsay, a senior lecturer at Sheffield University, advised physicians at an international symposium here, to tell their hypertensive patients to go easy on coffee and stay away from cigarettes if they want their medication to work. In studies of mildly hypertensive caffeine drinkers, the cigarette-coffee combination raised blood pressure significantly and blocked the action of thiazide diuretics, propranolol and oxprenolol.

Abuse study funded

OTTAWA —. Two Ontario women's groups have been given federal funding to study alcohol and drug abuse and other medical and mental health problems. The Women and Health Sub-Committee of the Northwestern Ontario International Decade Coordinating Council in Thunder Bay received $70,539. The group will organize education projects and workshops that will address specific health problems aggravated by the isolation of the region. The second group, Women for Women, of Sault Ste Marie, has received $32,215 to study the health care needs of women, educate the public, and circulate a brief to policy makers reflecting their concerns.

MDs want right to collect no-consent blood samples

TORONTO — The Canadian Medical Association (CMA) wants doctors to have the right to take blood samples from impaired drivers without their consent.

Dr Robert MacMillan, who seconded the motion on this issue at the CMA conference in Saskatoon, said such a law would require motorists, as a condition for securing a licence, to sign a document allowing physicians to take blood samples for the detection of alcohol if the person is involved in an accident.

Dr MacMillan, regional coroner for Eastern Ontario, told **The Journal** there are too many instances of someone in an accident being too impaired to take a breath test. In some cases, the drunk driver is injured and taken to the hospital, and no breath test can be taken.

Although it's obvious the driver has been drinking, he won't be prosecuted because there is no legal evidence of blood alcohol level, Dr MacMillan says.

The CMA has taken this stand because the problem of drinking and driving has grown to "epidemic proportions," Dr MacMillan says. Currently, doctors don't have the legal right to take blood samples from people injured in car accidents if they are unconscious or if they refuse.

The CMA motion will be sent to the various provincial medical associations and then to the attorneys-general for consideration. Dr MacMillan says it may also be possible that legislation could be introduced as a private member's bill.

He compares this proposal to seat-belt legislation introduced in some provinces in the 1970s. Although some will argue the doctor's motion is a violation of civil rights, "what about the civil rights of the guy who is run down (by a drunk driver)," Dr MacMillan says.

He adds that taking blood tests of people in emergency wards doesn't present any risks to patients, and will help ensure that drunk drivers are penalized.

Other doctors at the conference echoed Dr MacMillan's comments saying the interests of the public in these cases must be put ahead of the rights of the individual.

MacMillan: drunk driving is epidemic

AA enhances improvement: report

By Mark Kearney

TORONTO — One of the first statistical studies of Alcoholics Anonymous (AA) shows clients may have a better chance of solving their drinking problems than non-AA members, says a New Brunswick researcher.

David McTimoney, director of research and evaluation with the Alcoholism and Drug Dependency Commission of New Brunswick, says "initial indications" suggest AA affiliation for a year, seems to enhance overall improvement. The study began in April, 1980 and further evaluation is planned.

Of the 324 clients in the study, 174 reported no contact with AA and 150 were AA members. The majority of follow-up subjects were male.

At the start of the study, 53% of the non-AA members and 46% of the AA clients reported drinking every day. After a year only 16% of the AA members reported daily drinking compared to 28% of the non-members, Mr McTimoney says.

"It is further interesting to note that at the 12-month interval, those reporting AA affiliation also reported less morning drinking, fewer memory lapses, fewer hallucinations, fewer quarrels, and less drinking on the job than the non-AA affiliates," he told delegates at the Canadian Addictions Foundation's Special Interest Group on Program Evaluation meeting in Regina.

For example, 23% of the non-AA members reported they didn't drink in the morning compared to 15% of AA members. A year later this number had jumped to 59% of AA members compared to 43% of non-AA subjects.

The report also found that individuals who remained in contact with AA were more likely to be employed. While there was a slight drop in the number of non-AA members who regarded their job as the major source of income over the 12-month period (to 38% from 41%), AA members reported a steady proportional increase (to 45% from 34%.)

However, Mr McTimoney notes, of the 324 subjects at the start of the study, 82 (25%) dropped out by the end of the year "and the drinking patterns of the dropouts (if known) might sway these findings." In some comparisons made in the study the percentages increased while the absolute numbers didn't.

Manuella Adrian, head of the statistical information section of Ontario's Addiction Research Foundation, says some conference delegates expressed concern that comparisons were made between the 324 repondents in the baseline group and the 242 in the final group. It's possible that those who stayed in the study may have different personalities than those who dropped out, she said.

However, she says Mr McTimoney made it clear the results are only initial findings. Evaluation and comparisons may be done later using only the 242 who completed the study.

Ms Adrian says the initial findings are a step forward because they give a quantitative analysis of how AA works. Such statistical data may help determine what type of people are best suited for AA, help with referrals, and provide valuable information to AA itself, she adds.

Crop substitution preferred

Haislip

Jeri

Pow

(from page one)

cotic Drugs (see related stories pages 1 and 7), said "farmers must be shown that they can earn well by licit plantations; that coca money means considerable local corruption, criminal activities, and community demoralization, plus tax evasion."

Under the terms of the Single Convention, coca plantations in Peru should already have been eradicated.

Said Dr Jeri: "Unfortunately, the chronic economic depression of Peru, the hidden illegal plantations, and the economic, criminal, and political influence of the cocaine gangs, have impeded the destruction of plantations and their replacement by nutritious crops."

He told **The Journal** the Peruvian government is seeking international aid to begin crop substitution programs, which, he estimated, would cost several hundred million dollars to implement. He is convinced the program can work.

Peru is experiencing a food shortage, and agricultural crops would benefit the economy by enabling the country to limit food imports, he said.

In Thailand, where villagers rely on opium as their only medicine, crop destruction only succeeded in making it more difficult for Thai officials gradually to introduce the concept of crop substitution.

Major Pow told **The Journal** some villagers are now accepting crop substitution. "But it takes time because working in agriculture is not like working in industry. You can't do it in one year . . . Opium has been growing for 100 years, and we can't stop it in 10."

Parent education on drugs part of US federal goal

(from page one)

carried out by the anti-crime task force in south Florida, which is having an effect on traffickers. (**The Journal**, October.)

This ranges from intercepting ships and planes on the high seas, with the cooperation of the US armed forces if necessary, to revising US laws and regulations to strengthen the government's hand.

The strategy says that in the field of education and prevention "our goal is to educate the parents of school-age children about drugs, and how to recognize and deal with drug abuse in their homes, schools, and communities."

Governments cannot do this alone and voluntary public effort is needed.

The administration will also work with doctors, pharmacists, and researchers to find ways to reduce the abuse of prescription and over-the-counter drugs.

As for detoxification and treatment of drug abuse, the strategy declares: "Many of the current treatment programs tend to approach the heroin addict as a victim. While people may be victims of heroin use, they continue to have a responsibility to society.

"Treatment programs should recognize and reinforce these responsibilities as part of conventional treatment approach."

The strategy says the overall program "will rely heavily on integrated and cooperative efforts of federal, state, and local governments, as well as on the close involvement of the private sector — both the business community and volunteers."

NEWS

Recession endangers health, policy chiefs must be aware

By Peter Unwin

TORONTO — People are more vulnerable to a wide range of health problems, including drug abuse, mental illness, cardiovascular disease, and suicide during economic recession, says Johns Hopkins University professor, Harvey Brenner, PhD.

A keynote speaker here at Crossroads 1982, a forum on urban stress, Dr Brenner recommends health and policy officials move from a "single chain notion of cause and effect," to a multi-causal approach that acknowledges the role of economic factors in determining general health.

Dr Brenner, author of *The Economy and Mental Illness*, is a professor of operations and behavioral sciences, as well as research scientist for Metropolitan Planning and Research, Johns Hopkins University.

Quoting a study for the Library of Congress, Congressional Research Service, Dr Brenner says a 1% increase in unemployment will increase the suicide rate by 4.1 percentage points. (Earlier speakers noted nearly 50% of attempted suicides were drug and/or alcohol related.)

Highlighting the complex interrelationships between economic factors and health problems, Dr Brenner suggests the dramatic increase in ischemic heart failure during the 1950s and 60s can be attributed to an economic upsurge that caused a great increase in consumption of animal fat and cigarettes, very heavy ethanol consumption, and a shift to "sedentarianism" in the workplace.

"Very heavy consumption," says Dr Brenner, "especially of high ethanol beverages, like spirits, on a population basis causes death very quickly, whereas wine and beer consumed moderately over very long periods have life saving effects.

"Moderate beer and wine consumption tends to decrease the cardiovascular mortality rate."

A major problem in pinpointing the cause of disease, says Dr Brenner, "are interactive factors, that, by themselves, are relatively harmless.

"Cigarettes, ordinarily, don't have much to do with cancer of the larnyx. In interaction with very heavy consumption of alcohol, however, they have a lot to do with it."

The relationship between seemingly unrelated factors also manifests itself in other problem areas, says Dr Brenner.

"The crime issue is a multi-faceted complex situation.

"Unemployment does influence the homicide rate but several other factors are of equal or greater importance. One is the growth of youth in the population. Another is alcohol. A third is narcotics use and the narcotics trade generally."

Such complex relationships, says Dr Brenner, "do not have to exist. We can break them. It is simply a statistical relationship and, furthermore, a relationship that changes.

"We are about to destroy, if we carry it through, the relationship between aggregate cigarette smoking and heart disease mortality. We can do that."

Because such factors as alcohol and cigarette consumption or the unemployment rate are subject to government policy, they can be influenced, says Dr Brenner.

"It becomes quite clear that what we are able to do nationally, in terms of policy, normally effects the mortality rate. The garden variety of economic decisions represent most of what is health policy.

"There are very profound social implications that are consequent on virtually every economic decision," he says.

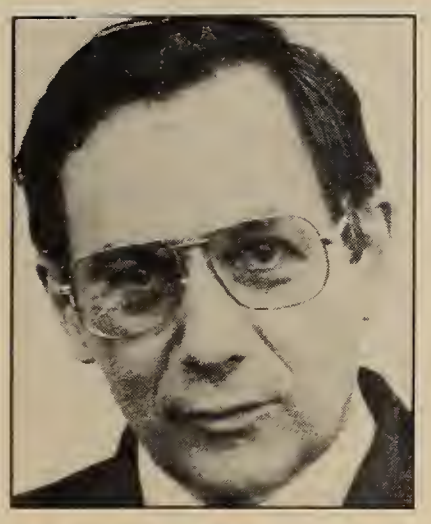
Heroin trade to Canada increasing

By Mark Kearney

TORONTO — The amount of heroin entering Toronto and Montreal is increasing, says Superintendent Rod Stamler, officer in charge of the RCMP (Royal Canadian Mounted Police) drug enforcement branch.

His comments come on the heels of an announcement by RCMP officials in early October that customs officers here had seized 215 grams of heroin worth $2 million, the largest seizure of the drug ever made at Toronto International Airport.

Supt Stamler described the seizure as "a very significant quantity," but said there are no figures to show what the percentage increase in heroin shipments has been this year compared to last.



Stamler: a competitive business.

He said much of this year's supply is being processed by European chemists, who figured prominently in the "French Connection days," and is of "a very high quality."

Supt Stamler said the original shipping point for the drug to Canada has shifted from Southeast Asia (the Golden Triangle of Thailand, Burma, and Laos) to Southwest Asia. Southwest Asian, or so-called Golden Crescent heroin, primarily from Pakistan, Iran, and Afghanistan, is shipped to North America through Europe.

Last year, about 80% of the drug came to Canada from the triangle area but that's dropped to about 60% this year, he said.

One reason for the shift is the Thai government has increased controls on some of the agents needed for the opium-to-heroin conversion process, including acetic anhydride (vinegar) which is produced in huge quantities in Western Europe and has had virtually uncontrolled exportation to the triangle area. With the controls, the conversion process is both more difficult and more expensive, said Supt Stamler.

Because "it's a competitive business" the heroin dealers are turning to southwest Asia where the drug is cheaper, he said.

If couriers are being used to bring heroin in from Europe, only about three out of 10 have to make it through customs for the suppliers to make a profit, he said.

"There is no way to physically interdict a high percentage of what's coming in (except) for short periods of time."

The RCMP and customs officials can step up surveillance of freight coming to Canada, but then suppliers will shift to passenger flights and vice-versa, he says.

Call for abstracts

Deadline is November 30, 1982 for abstracts of papers for the International Council of Prison Medical Services' Second World Congress on Prison Health care to be held in Ottawa, Aug 28 to 31, 1983. Papers on aspects of health care in prisons, particularly from abroad, are requested to be sent to: Congress Secretariat, Medical Services Branch, Correctional Service of Canada, Ottawa K1A 0P9, Canada.

Police laying more charges on alcohol offences in Ont

TORONTO — Charges laid by Toronto police under the Liquor Control and Liquor Licence acts have increased by 44% over the last two years.

The figures, published by the Ontario Ministry of the Attorney General, show charges laid increased to 40,523 in 1981/82 from 28,119 in 1979/80, in Toronto.

Total liquor-related charges for the province of Ontario jumped to 174,991 in 1981/82 from 145,163 in 1979/80.

Charges laid under the Narcotic Control Act and the Food and Drug Act for the same period in metropolitan Toronto, show an increase to 8,285 from 7,420, in the two year period.

Total charges under these acts for the province of Ontario, dropped slightly, however, to 27,126 from 27,388.

Paraphernalia law upheld

RICHMOND, VA — A United States federal appeal court has again upheld a state law banning the sale of drug paraphernalia.

The latest decision, made by a three-member court here, upheld Virginia's anti paraphernalia law, and, at the same time, rejected a claim by the National Organization for the Reform of Marijuana Laws (NORML) that police seizure of literature violated the first amendment.

In the suit NORML claimed the law allowed police to seize its literature as evidence of a shop-owner's intent to encourage drug use.

The appeal court ruled that a lower court judge was right when he said any impact on NORML's rights is incidental. The appeal court added in no way does the Virginia law prohibit NORML from carrying out its activities, nor is any of its published material outlawed.

Whistling in the wind for Brave New World

By Wayne Howell

Brave New World had initially gone up on the board at 20 to 1. At post time the odds were down to 10 to 1. If it had been smart money that had driven the odds down, it was very smart money indeed, for Brave New World had come off the rail at the ¾ pole and, with a little encouragement from the whip of jockey Manuel Sotuza, had won by a length, going away.

Now he was standing in a stable. Beside the sweat-stained thoroughbred stood Bob, his equipment at the ready. Bob patted the horse's steaming flank tenderly, then pursed his lips and exhaled slowly, in the prescribed manner. Nothing happened. He drew a fresh breath and began again, and had not Bill suddenly flung open the stable door perhaps he would have succeeded.

"Can't you see I'm whistling," said Bob disgustedly, as the horse made a soft whinny and shied away.

"Gee I'm sorry," said Bill, "I was just so excited I couldn't wait to tell you."

"Tell me what?"

"There's a whole new future opening up for guys like us. They've developed a urine test for marijuana in California. People like Carlton Turner, the US presidential advisor on drug abuse policy, and Dr Robert DuPont, president of the American Council on Marijuana, are gung-ho on using it in business and industry to ferret out those workers who are responsible for our failure to meet the Nipponese challenge."

"So."

"Don't you see. They're going to need guys like us — piss whistlers — in Ford and Chrysler, General Motors, and IBM. The possibilities are limitless."

"I wish you wouldn't use that term," said Bob. But even as he spoke he realized the futility of his statement. Ever since post-race urine testing had become mandatory at race tracks across North America, and ever since some bright mind had seized on the idea of using classic Pavlovian conditioning to get the horses to perform on cue, those government employees delegated to collect the samples by stimulating the horses with an auditory signal had been known in racetrack argot as "piss whistlers."

The alliterative epithet was inevitable, thought Bob, and there was nothing you could do about it. He shook his head with resignation and began, again, to whistle softly to the horse.

"Hey man. This is the biggest thing to happen on the piss-whistling scene in years and you act like you don't even care."

"You don't really think they're going to treat human beings like horses," said Bob, as he stood up and strapped a plastic-bag collection device on Brave New World. (He always felt like a failure when the whistling didn't work although he knew he had no real reason to feel that way; the damned horse was one of those ones that just wouldn't, or couldn't, respond to the signal. There were always a few like that.)

"Looks like it to me," said Bill. "These guys are all in favor of testing, even though the test won't show whether you smoked three joints in the last three hours or one-third of a joint in the last three weeks — it's about as useless as our Butazolidin test but they want to give it to the workers anyway."

"Really," said Bob. He shook his head bemusedly. The idea of piss whistlers in business and industry was certainly weird — but then it was only two more years until 1984. Who could say what might or might not be possible by then? It certainly would be nice to get out of the stables. Maybe a little office near personnel — nothing fancy, mind you. With a little plaque on the wall saying "PWD." No, no, not the Piss Whistler Department, that would never do: it would say "NWAU" — the Nitrogenous Waste Analysis Unit.

New vistas were opening up to Bob. There was just one nagging question.

"What happens," said Bob, as he glanced at his watch and scowled at the recalcitrant urine-retentive horse, "if the employees don't come through: do we call in the vet to stick 'em in the neck for a blood sample?"

"Hey, come on. Get serious. They'd use company doctors and they'd stick 'em in the arm."

"I guess you're right," said Bob. Brave New World nodded his head, as if he were in agreement.

NEWS

RESEARCH UPDATE

Wednesday is the driest day

The driest day of the week isn't Monday, but Wednesday, indicates a study of the drinking habits of Canadians. Drawing on data from the 1981 Canada Health Survey, Prem Khosla and W.J. Bradley of Health and Welfare Canada found that alcohol consumption by both males and females follows an identical pattern through the week. After the Wednesday low, there is a steady escalation through Saturday, with women, however, doing a higher proportion of their weekly drinking on Saturday than men. Sunday consumption levels are only a little lower than Friday's. Monday and Tuesday continue the downward trend. For males, the Friday through Sunday period accounted for 54% of the week's drinking, while for females the weekend accounted for 56.9% Of the 11,273 current drinkers surveyed, only 15% said that they hadn't had a drink during the preceding seven days.

Chronic Diseases in Canada, September 1982, v.3:2-27

THC in the body found long-lasting

THC from marijuana can persist in the body for at least three weeks, indicates a study of urinary THC levels in a patient who was supervised and had no access to THC-containing drugs. The authors, who believe that such lengthy persistence of cannabinoids has not been previously confirmed by testing, also provide data on six other, non-supervised patients who had heavy marijuana use before admission to hospital and continued to excrete THC for as long as 36 days after admission. Their data imply, the authors note, that "even infrequent use could ensure a continuous presence of drug in the body."

American Journal of Psychiatry, September 1982, v. 139: 1196-1197.

Clue to FAS prevention?

Some of the teratogenic effects of alcohol may be prevented by supplementing the mother's diet with oil from the seed of the evening primrose, suggests an initial animal study. Drs Vid Persaud and Parmeen Varma, working at the University of Manitoba, gave three groups of pregnant rats plentiful access to food and water but also supplemented their diets with either alcohol, alcohol plus evening primrose oil, or evening primrose oil alone. Nine days into the pregnancy, the animals were sacrificed and the condition of the embryos was examined. In the great majority of rats who had been exposed to ethanol alone, embryos showed severe abnormalities of early development. On the other hand, in rats treated with ethanol plus evening primrose oil, or evening primrose oil alone, embryos showed far fewer abnormalities. The apparent protective effect of the evening primrose oil could arise, the researchers say, from the fact that it supplies an essential fatty acid — gamma-linolenic acid — which is depleted by alcohol consumption.

Prostaglandins, Leukotrienes and Medicine, 1982, v. 8: 641-645.

Learning to love those powerlines

Powerlines are addicting, says Dr Cyril Smith of the University of Salford, England. The researcher says that powerful electromagnetic fields can stimulate production of endorphins, the endogeneous "painkiller" compounds that are chemically related to morphine. He calculates that people and animals living within 100 meters of an overhead powerline would be subject to currents of approximately 100 microamperes passing through the body. Such currents — similar to what is used in electroacupuncture — are imperceptible but would produce significantly elevated endorphin levels so that, when away from the powerlines for a few days, the person or animal could experience withdrawal.

The Medical Post, September 21, 1982:66

Fungi can slip through waterpipe

Smoking marijuana with a waterpipe would seem to be a reliable way of ensuring that fungal spores in the drug (**The Journal**, April, 1981) don't make their way to the smoker's lungs. Not quite so, say researchers from the Baltimore Cancer Research Center who report that when four samples of marijuana were test-smoked with a waterpipe, spores of the fungus *Aspergillus flavus* were recovered from all the water units in the pipes, and from one of the mouthpiece filters. While danger of lung infection is minimal for the healthy, immunosuppressed cancer patients using marijuana to ease the nausea brought on by chemotherapy, could contract a serious infection.

New England Journal of Medicine, June 17, 1982:1492-1493.

A drag on the pipe

All pipe smokers inhale to some degree and some inhale a lot, indicates a study of the plasma nicotine levels of three groups of smokers: those who have never smoked cigarettes, those who have long since given up smoking them, and those who still, at least occasionally, light up a cigarette as well as a bowl. The researchers, led by Dr Kevin McCusker, now of Washington University School of Medicine, St Louis, found that nicotine levels of all the subjects were similar (3 nanograms per millilitre) before the first bowl of the day, but became quite disparate after the first bowl had been smoked. Those who had never smoked anything but pipes went up to 4 ± 3 ng/mL. Those who had completely given up cigarettes went up to 6 ± 7 ng/mL. And those who still smoked cigarettes too went up to 22 ± 18 ng/mL, which is much the same as the nicotine level of cigarette smokers who inhale.

Journal of the American Medical Association, Aug 6, 1982, v. 248.577 578.

Austin Rand

Hard times may bring more clients to already-flagging treatment area

By Eleanor LeBourdais

RICHMOND, BC — Tough economic times could lead to shifting patterns of alcohol and drug abuse, and to additional strain on already-stretched treatment services, says the president of Ontario's Addiction Research Foundation.

On the one hand, people may drink less as the price of alcohol relative to income increases. Or, they may drink more because of stress and anxiety caused by the economic climate, Joan Marshman said here at the 1982 Pacific Western Conference on Alcohol Problems.

At the same time, layoffs of marginally efficient employees with alcohol and drug problems could mean an increase of potential treatment candidates.

Dr Marshman said research now indicates that adverse physical consequences result from lower levels of alcohol consumption than previously recognized. Thus, treatment needs to be directed to a broader range of consumers.

"There is a growing potential client population," she said, "but little evidence of significant expansion of treatment services to deal with it, and little evidence of great increases in the efficiency of treatment resources."

As always there are funding priorities. "Do policy makers recognize that alcohol-related morbidity and mortality constitute major probems for the Canadian people? When will they give appropriate attention to treatment services for alcoholism?

The public in general must make its views known to the policy-makers if it expects to have any impact on the action taken, Dr Marshman added.

Meanwhile, ways must be found to make more effective and efficient use of the current resources, she said, adding that fragmentation of services contributes to malfunction.

Dr Marshman said alcoholics identified within the traditional health care network in Ontario tend to be referred within that network; those identified by social services tend to stay in that segment, and there is little cross-over into each other's territory, with the exception of referrals to Alcoholics Anonymous.

"The consequence of this closed system," she said, "is that interventions tend to be related to only one segment of the problem — physical or mental health on the one hand, or employment, family, or social relationships on the other. This kind of fragmentation does lay the groundwork for the 'revolving door' use of services."

Dr. Marshman said another problem is isolation of treatment from the real world.

"I won't deny that some alcoholic clients need time out from the stresses and problems in their real world, and that some supportive living environment is necessary. But the client who is shipped off to a residential program of several weeks' duration, and then released abruptly back into his regular environment without an opportunity to practise those newly-learned behaviors in some supportive place, will find the new behaviors aren't reinforced. He's going to experience some kind of culture shock or relapse."

She said one of Alcoholics Anonymous' strengths lies in its real world base with the maintenance of mutual support in the context of the clients' own environment.

Dr Marshman stressed the need for change in response to emerging knowledge: "The outcome of treatment is more closely correlated with the characteristics of the client than with the characteristics of the intervention."

Marshman: emerging knowledge.

She warned against inertia and fear of change. She said even senior policy makers may be reluctant to initiate new programming directions.

"But if we don't plan and initiate change from within, changes may be made by others from the outside, who don't really appreciate the positive aspects of our current efforts. They may 'throw out the baby with the bathwater' in the name of cost containment, or reduction, or coordination."

In the final analysis, Dr Marshman said, treatment systems should be viewed within a systems concept.

US surgeon-general calls on physicians

Anti-pot warnings urged

WASHINGTON — Doctors in the United States have been asked by the Surgeon General to try to discourage marijuana use by their patients and to advise parents about its dangers to young people.

In his statement to doctors, US Surgeon General Everett Koop said: "The health consequences of marijuana use have been the subject of scientific and public debate for almost 20 years.

"Based on scientific evidence published to date, the Public Health Service has concluded that marijuana use has a broad range of psychological and biological effects, many of which are dangerous and harmful to health."

Dr Koop said the recent advisory on *Marijuana and Health* issued by Richard Schweiker, US secretary of health and human services, was based on two comprehensive scientific reviews on the subject: one by the Addiction Research Foundation of Ontario in collaboration with the World Health Organization (**The Journal**, January 82, May 81), and the other by the US National Academy of Sciences (**The Journal**, April).

Both reviews corroborate prior findings of health hazards associated with marijuana use. Dr Koop added: "I am especially concerned about the long-term developmental effects of marijuana use on children and adolescents who are particularly vulnerable to the drug's behavioral and physiological effects."

BC's Mair wants anti-drink ads

RICHMOND, BC — Former provincial minister of health Rafe Mair wants the British Columbia government to impose a 10% surcharge on the sale of liquor and use the money for a province-wide anti-drinking campaign.

Mr Mair made the recommendation at the Pacific Western Conference on Alcohol Problems here.

He suggested the first step should be an advertising campaign to change public attitudes about drinking. "I'm not concerned so much with the effect advertising has on older people. It's the impact it has on 10- and 12-year-olds that bothers me."

Mr Mair identified alcoholism as "the most serious health and behavioral problem in this country." He said a campaign geared to discourage use of alcohol would not only contribute to solving alcohol-related problems, but would also save BC an enormous amount of money.

"Alcohol costs this province a staggering $1 billion per year."

Mr Mair also backed implementation of stiffer penalties for drinking and driving. "If they're caught once, suspend their licence for a year. If they're caught again, take away their right to drive forever."

He criticized the provincial government's May decision to lift the ban on radio and television advertising of beer and wine products. "I used to be more liberal in my views, but when I looked into the question of liquor advertising I concluded there's absolutely no good case whatsoever in favor of it."

NEWS

'Flourishing growth has come to a screeching halt,' says Mayer

US institutes will stay separate, do research

By Harvey McConnell

WASHINGTON — The three institutes which make up the United States Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) will remain separate entities, says ADAMHA director, William Mayer.

"The fact the federal government is changing its role does not mean in any way — and I have this both from the (Health) Secretary (Richard Schweiker) and the President (Ronald Reagan) — any diminishing of the federal interest and concern," Dr Mayer told the annual conference here of the Alcohol and Drug Problems Association of North America (ADPDA).

Dr Mayer said the United States, like Canada, Mexico, and most of Western Europe, is in a state of economic crisis, and the National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA,) and National Institute on Mental Health (NIMH) are caught in the middle.

Dr Mayer: "After 10 years of flourishing growth, a rapid rise of expectations of what we could do, and a rapid rise of the resources to do it with, tremendous inroads were made against the stigmas of substance abuse; a more rapid increase than any other branch of medicine. It has now come to a screeching halt."

The last 10 years have seen a proliferation of programs, many of which were hard to oversee and control some 2,000 or more miles away from Washington, he said. This led to a plethora of rules, regulations, guidelines, restrictions, audits, checks, and balances.

Dr Mayer said the essential question is: how much can the US federal government afford to pay for the emergence, in the last 30 years, of a legitimate health enterprise into the problems associated with peoples' minds and behavior, and with peoples' use and abuse of mind- and emotion-altering compounds.

Dr Mayer said there has been talk in the last year of dismantling the ADAMHA, putting the NIDA and the NIAAA back into the NIMH, and returning the whole package to the National Institutes of Health. "This is very inaccurate and I have opposed this idea."

The directors of the institutes have more immediate access to more factors, or what approaches truth, concerning the nature of these problems, and what may or may not work in dealing with them, than anyone else in the US, he said.

"I know if the ADAMHA were to change and be put back into the National Institutes of Health, I know in my own heart, in view of the fact that there is much resistance to programs such as ours arising within the health professions, that they would not fare well. They have fared very well outside of this," Dr Mayer said.

He said the three institutes have, in the past, operated on the basis of "benign bribery," as have many government enterprises.

In other words, "you want to run a good treatment program and you need some money from us to do it. Okay, we will give you the money, but these are the conditions: you do what we want or you don't get our money.

"A simple straightforward contractual agreement. But you all know it is possible to deviate significantly from what you say you are going to do, or what you say you are doing, and still get away with it, barring an army of investigators out there looking over your shoulder. You can no longer do that."

Dr Mayer said that money now available to the institutes is going to be devoted to research that is relevant to the charges of the institutes. "That charge by the Congress, which makes the laws, is that we will discover the causes, the treatment, and prevention of mental disorders and problems related to alcohol and drug misuse or dependency."

Research will be supported that will add to the knowledge in these areas. But no longer will the budgets of the institutes be devoted, in large part, to programs to train people or to deliver services.

Dr Mayer said the research will not be academic exercises that will eventually trickle down. The institutes will collect epidemiological data and attempt to see what works and what does not work.

Research must be translated into useful techniques and information. "I do not subscribe to the idea we have to have total and final answers to all the questions about these disorders before we do anything about them," Dr Mayer added.

The institutes should proceed on the basis of the best empirical knowledge they are able to collect.

Dr Mayer continued: "Our institutes will remain separate because they are different, and because they have a much wider responsibility. Other institutes, such as cancer or heart disease, do not have the same history or the same responsibility for the kind of general public interest, education, sharing of information, and collecting of data."

Forced treatment can work for some alcoholics

By Mark Kearney

TORONTO — There is nothing wrong with forcing an un-cooperative alcoholic into an employee assistance program (EAP), says Robert Porter, an assistant vice-president, health and safety, of Bell Canada.

Dr Porter says one myth surrounding EAPs is that alcoholics won't succeed in a treatment program unless they want to. While that may be true for some, he says, others will reject help initially but seek it later.

A company should place the alcoholic in the program. Then when he is ready to stop drinking, help and treatment are available, he says.

"Yes, you can force somebody into treatment and hopefully they will take advantage of it," Dr Porter said at a recent symposium here, entitled Addictions: Separating Fact from Fiction. "We're not ashamed of coercing a person into treatment."

Bell Canada has had a successful program for 30 years, Dr Porter told the symposium, and the company has treated alcoholics as it would treat any employee with a disease. Employees aren't fired until all options are tried, but the worker has to be responsible for his actions.

"He should suffer and feel his disease," Dr Porter says. If fellow employees cover for the alcoholic, he won't "hit bottom" and realize he needs help.

Managers should also be involved in the program to ensure they're aware of the employee's progress and needs, and to watch for signs of a problem and take steps to check it.

"If a manager accepts substandard behavior then that's what he'll get," Dr Porter adds.

The alcoholic who is successfully treated, however, can't always expect to fit back into the workplace easily, he says.

"Sobriety never promises you a rose garden," and the alcoholic must realize fellow workers may resent having covered for him for so long, and then seeing him return without any apparent punishment, such as being fired, Dr Porter says.

Gordon Bell, president of the Donwood Institute in Toronto, echoed Dr Porter's concerns about addiction, calling it society's "greatest unresolved health problem."

Dr Bell says cross-addictions (to both alcohol and tranquillizers, for example) are becoming more widespread because a "host of medications" is available now. Cross-addiction usually requires longer in-patient care and more intensive treatment than a single addiction, he says.

Dr Bell says earlier intervention and, ideally, primary prevention and the development of alternative lifestyles are needed to compete with the initial pleasures "the chemical world" can provide.

Edward Sellers, director of the clinical institute at the Addiction Research Foundation, says studies seem to indicate that a "multiplicity of programs" can work to reduce drug dependency. A "concerted, broad brush program" has been effective in reducing the use of tranquillizers over the past five years, especially among women, Dr Sellers says.

The Journal's columnist, Dr Wayne Howell, left, chairman, and panel members, Drs Sellers, Porter, and Bell at symposium entitled Addictions: Separating Fact from Fiction.

GILBERT

Richard Gilbert is on vacation. His column will resume next month.

US will hand out millions in grants to states that follow DWI guidelines

WASHINGTON — A new United States federal drunk driving bill makes $125 million available to states meeting four essential requirements.

To be eligible for grants under the new highway safety fund established by congress, the states will have to:

- set a 0.10% blood alcohol content as the definition of legal intoxication; and suspend a licence for a minimum of 90 days for a first offence and no less than one year for a repeat offence. Licences would also be revoked for anyone who by a chemical test is deemed to be driving while intoxicated, or is suspected but refuses to take the test;
- sentence repeat offenders (within five years) to 48 consecutive hours in jail or 10 days community service.
- bolster enforcement of state drunk driving laws; and
- increase efforts to inform the public about drunk driving.

Even more money can be obtained by states that meet additional criteria to be established by the secretary of transportation. These may include: a record system to track repeat offenders; setting the minimum drinking age at 21 years; impounding a vehicle operated by a repeat offender; granting pre-sentence screening authority to the courts; and having locally-coordinated and financially self-sufficient drunk-driver control programs in each major area of the state.

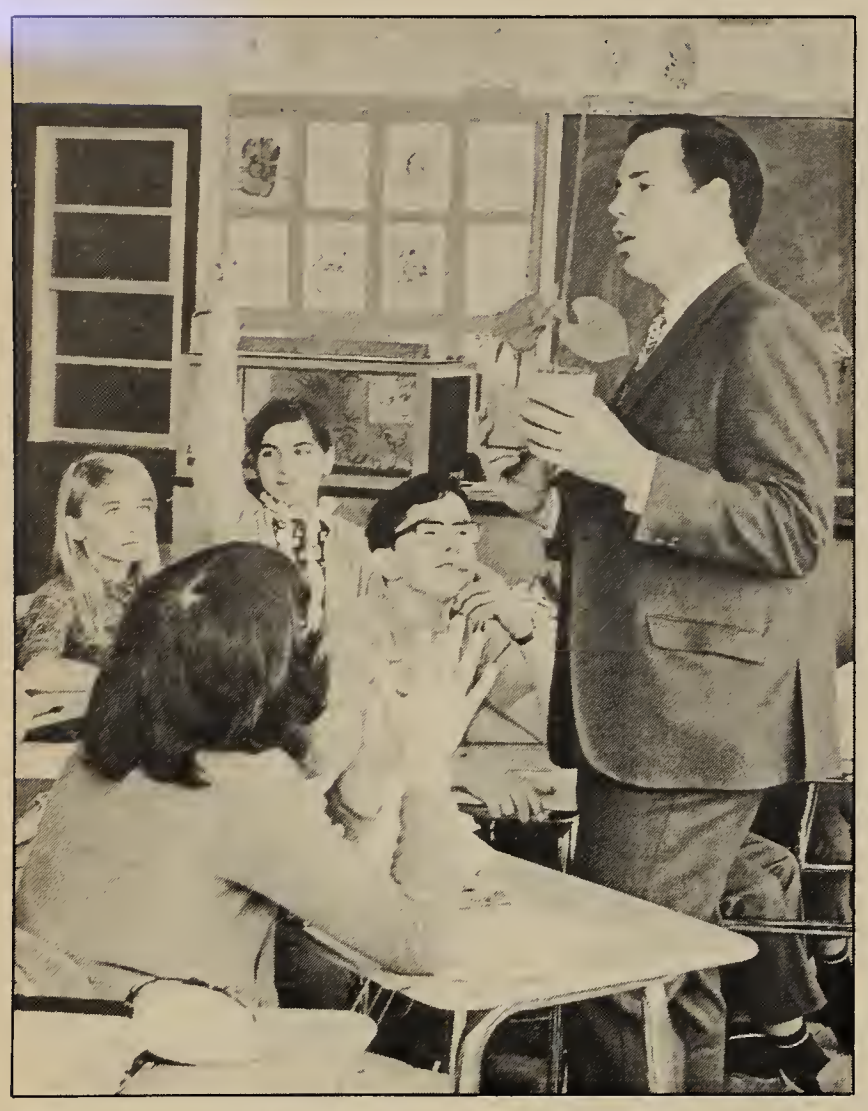
The bill provides $2 million to computerize the national driver registry — making it easier to determine previous drunk driving convictions in other states.

Drunk and drugged driving awareness

WASHINGTON — In the spirit of raising public awareness, and on the coattails of major legislation which guides states in setting up model drunk driving laws, the week of December 12-18 in the United States has been declared National Drunk and Drugged Driving Awareness Week.

Sponsors, representatives Michael Barnes and James Hansen, who are also on the presidential commission on drunk driving, hope the awareness week will alert the public during the holiday season that the roads can be deadly when alcohol and drugs are used behind the wheel.

NEWS



Waterloo school program shows smoking-prevention message works.

Pilot prevention program effective, students are less likely to smoke

By JANE WILSON

WATERLOO — Two years after participating in a smoking-prevention program, students at 22 elementary schools in this area are significantly less likely to be smoking cigarettes.

Those who benefit most from the program are students who entered the study with strong inclinations to smoke.

The 654 grade six students involved in the pilot study, conducted by Dr Allan Best, of the University of Waterloo, and Shelagh Towson, were split into two groups.

Half the group received six one-hour sessions about the consequences of smoking; how to resist the influences to smoke from the media, relatives, and friends; and how to make a personal decision about smoking. The program included class discussions, films, and skits. Questionnaires and maintenance sessions followed.

The other group did not receive instruction, but completed questionnaires.

A review of the results after two years showed:

— Seven per cent of the students in the prevention program had experimented with smoking, compared to 18.6% of those with no program;

— 32% of those in the program had never smoked, compared to 27% of the control group;

— 31.8% of those in the program reported they had quit smoking, compared to 26.5% of the controls;

— Seven per cent of those in the program were regular smokers compared to 8.8% of the controls.

Results indicate that, in addition to smoking less often, children who were regular smokers in the program group tended to report having smoked fewer cigarettes during the week prior to testing.

Students who were experimenting with cigarettes or who had quit smoking were most influenced by the program, the report said.

A second phase of the study begins in January, involving 75 schools in seven Ontario school boards. The funding of $206,000 for two years comes from the Ontario ministry of health.

Sri Lanka in drug trouble

By Lachlan MacQuarrie

COLOMBO — While the problem of substance abuse in Sri Lanka may not be as chronic or severe as in many neighboring countries of the Asian Region, it has reached the point where it represents a threat to national security, as well as to economic and social development.

This view was expressed in a report submitted by consultant Vis Navaratnam, of the World Health Organization's Centre for Research and Training in Drug Dependence in Malaysia. Dr Navaratnam was commissioned by the government of Sri Lanka to "obtain all relevant data necessary for the determination of the extent of the problems of drug abuse . . . and to advise the government on the development of a national strategy to manage these problems."

Dr Navaratnam visited Sri Lanka in May and June 1980, and in a preliminary summary of his findings noted the major drugs of abuse were opium and cannabis. He also found some evidence of abuse of psychotropic substances (mainly seconal, diazepam, and luminal), as well as indications of a recent increase in heroin trafficking.

Navaratnam: consequences may be disastrous.

Opium addiction is a heritage from a time when the sale of opium was not illegal in Sri Lanka, and not surprisingly therefore, opium abusers tend to be in the older age groups.

There are no addiction rehabilitation programs in Sri Lanka and treatment of drug dependency is limited to a few selected psychiatric clinics and mental hospitals. Chronic opium users are the largest group seeking treatment.

Dr Navaratman said there is evidence of an increasing level of cannabis use by younger members of the local population.

There are no precise figures on the number of drug abusers in the Sri Lankan population of 15 million. Dr Navaratnam's report estimates 50,000 opium users, and 130,000 cannabis users. However, local officials say these estimates are too high, and statistics more often quoted are 15,000, and 50,000 for opium and cannabis users respectively.

The opium poppy is not grown in Sri Lanka, so opium and derivatives must be imported. There is, however, extensive illegal cultivation of cannabis, mostly in the jungle areas in the south-eastern portion of the country.

Dr Navaratnam's report estimated that Sri Lanka produces about 1.7 million kilograms of cannabis annually. Since the estimated annual consumption within the country is approximately 525,000 kilograms, it can be deduced that close to 1.2 million kilograms enter the illicit international market.

"This puts Sri Lanka in the league of the top exporters of cannabis in the world," Dr Navaratnam said.

The consultant also advised there is evidence that No. 5 heroin has recently become available on an increasing scale. This opinion seems to have been confirmed by the largest seizure of heroin ever made in Sri Lanka in August, 1982.

"It is imperative that (Sri Lanka) acknowledges the existence of the presently controllable problem and institutes appropriate remedial measures . . . otherwise there may be the disastrous consequences which many nations of the region have experienced," Dr Navaratnam stated.

MDs do respond to tactful intervention

WASHINGTON — Most doctors are amenable to being told some of their patients may be abusing prescription drugs — if they feel they are not being blamed.

This is the experience of Shirley Coletti, executive director of Operation PAR, in St Petersburg, Fl, a program for elderly people with drug and alcohol problems.

Ms Coletti told the annual conference here of the Alcohol and Drug Problems Association of North American (ADPA) that "one thing which is constantly coming through is the very high incidence among the elderly of prescription drug abuse."

Ms Coletti said: "The problem with so many elderly (people) is that they go to one doctor for their arthritis, one for their heart complaint, or another for their diabetes, and each of the doctors prescribes drugs, and there is very little interchange of information unless the patient is sharp and realizes there may be potential problems."

Ms Coletti said when program workers contact doctors, with patients' permission, "we are finding that most doctors, if approached in a non-blaming way, are receptive to our calling. They want to work with that patient and we are having a fair amount of success."

Pharmacists, however, are less willing to call doctors to point out possible conflicts in medications prescribed; they believe doctors will take umbrage, she said.

"However, at least in our area, we are seeing a marked decline in writing of prescriptions which can be abused by the patient," Ms Coletti said.

Treatment centre for women only concentrates on wellbeing, lifestyle

By Rhonda Birenbaum

ST. CATHARINES — Canada's second addiction treatment program exclusively for women has opened here.

Aurora: Community Women's Alcohol and Drug Treatment Program began offering out-patient detox services in the Niagara peninsula in October.

Coordinator Judith Wills told The Journal the new project will attempt to meet the needs of addicted women not met by male-oriented programs.

"Existing programs fail to deal specifically with women's issues," Ms Wills said. "They are often over-represented by men, to a ratio of 10 to one, and women tend to hold back. Consequently their follow-up is often prolonged."

A women's only program, such as Aurora, will address the issues neglected by conventional detox programs, Ms Wills said.

"Women drink for different reasons. Their drinking escalates more quickly than men's. They are often cross-addicted, and suffer different physical and emotional effects from their addictions," she said

These issues don't come out in mixed (male and female) treatment sessions, said Ms Wills, who is just completing a part-time course in Addiction Counselling at George Brown College in Toronto. Ms Wills has been involved with the community Alcohol and Drug Follow-up Program in the Niagara peninsula for six years in various capacities.

The program involves 12 days of sessions that include education about the effects of alcohol and drugs on the female body, sexuality and family relations counselling, stress management, and lifeskills training.

Counsellors encourage women to be open about their medical and emotional problems — an important phase of treatment missing from other detox programs, said Ms Wills. Women are also exposed to transactional analysis to examine their roles in the family, the community, and the workplace.

Aurora has been patterned after Ottawa's women's addiction centre, Amethyst, which opened in 1979 as the prototype in women's outpatient detox treatment. Both centres are based on the philosophy of helping women to reconcile their personal images and roles in society, and to become responsible for their own wellbeing, lifestyle, and health.

Aurora program recognizes 'women drink for different reasons.'

NEWS

No help, no money, and little official recognition

Peru's thousands of addicts 'have no hope'

By Karin Maltby

TORONTO — In the face of a growing epidemic of cocaine use among Peruvians, many politicians there refuse to believe the drug is an issue for concern.

And they are wrong, says Federico Raul Jeri, chairman of the Drug Addiction Committee, the Ministry of the Interior, in Lima, Peru.

"We have thousands of drug addicts who have no possibility of help," Dr Jeri told **The Journal**. There are an estimated three million coca chewers, 156,000 coca paste smokers, and 84,000 cocaine hydrochloride (sniff or freebase) users in the country, he added.

Yet, there is a general belief among Peruvian politicians and other professionals that illicit cultivation of cocaine, and its resultant traffic into other countries — notably the United States — is a concern that should be addressed by those nations.

This false consensus has left Peru bereft of a specific budget for drug education, rehabilitation, and enforcement programs, said Dr Jeri.

Jeri: bereft of a special budget for drug programs.

"We have a national budget and we could assign some of those funds. This has not been done because some politicians think the drug problem in Peru is not significant — that it doesn't affect Peru; that it affects the US."

Dr Jeri, a psychiatrist and cocaine researcher, (**The Journal**, July) said Peru should take more responsibility for funding needed programs by diverting citizens' taxes for these purposes, and not "wait for international aid."

"Another means of financial support could be money from vehicles and assets confiscated during drug seizures. By law, part of that money should go to enforcement and prevention. Now it just goes to the Treasury, and they do with it what they will."

Dr Jeri said, however, that Peru, as a developing country, needs foreign financial support because the volume of drug traffic is so great officials are unable to control Peruvian ports, airports, and borders.

Dr Jeri was in Toronto in October to attend a meeting at the Addiction Research Foundation on the United Nations 1961 Single Convention on Narcotic Drugs (see page 1.)

He told the meeting that "in the last few years, the police have caught American, Argentinian, Canadian, Colombian, Cuban, Ecuadorian, French, Italian, and Venezuelan nationals of both sexes transporting cocaine in airplanes, boats, ships, cars, and trucks, and the convictions among Peruvians have increased considerably."

Dr Jeri added: "Police officers have been convicted of selling confiscated cocaine, or permitting delinquents to escape after receiving appropriate bribes. Lawyers become wealthy defending drug criminals. Judges also gave freedom to delinquents who were charged with narcotic smuggling."

While some action has been taken by the government to control corruption, Dr Jeri said other measures must be adopted to eliminate the problem.

This year the Peruvian government has adopted five main policies as priorities in drug control:

- intensification of police and customs activities;
- comprehensive studies to substitute coca plantations;
- educational preventive programs in secondary schools;
- epidemiological drug research in one or more cities;
- establishment of treatment units in general hospitals.

Polydrug user profiles getting messy

By Harvey McConnell

WASHINGTON — The sound practice of medicine is the one way doctors can help combat chemical dependency.

Legal and illegal social drugs, over-the-counter drugs, and legally and illegally obtained prescription drugs, are being used indiscriminately by a growing number of people. For many of them the future is grim, says Lieutenant Commander Curtis Wright, former outpatient medical officer of the Tri-Services Alcoholism Facility, (US) Naval Medical Center, Bethesda, Maryland. Dr Wright is now staff physician, emergency room, at the Naval Hospital also in Bethesda.

"They use multiple synergistic medication to achieve, in five years or less, the kind of destruction of identity which takes the alcoholic 30 to 40 years of heavy, steady, daily drinking to achieve."

A different kind of patient profile is developing he told the annual conference of the Alcohol and Drug Problems Association of North America here.

Military treatment facilities are beginning to see 18-year-old servicemen who have become involved with illegal drugs and black market prescription drugs.

It is not unusual to find a worker in his 20s who has an alcohol problem, smokes marijuana occasionally and tobacco regularly, drinks myriad cups of coffee daily, takes an amphetamine analogue for obesity and antihistamines for allergies, and, as well, uses prescribed tranquillizers, sleeping pills, and muscle relaxants.

"What do you call this guy other than a mess? You call him chemically dependent," Dr Wright added.

What is happening is medically sanctioned addiction.

Dr Wright said there is a class of individuals which seem to develop a group of diseases "where the individual's stress level, mood level, and comfort seem to be related, more than with other illness, to the degree to which the individual will express symptoms."

Dr Wright said the complaints are of a variety of ailments, from asthma, migraine, low back pain, and stiff jaws, to hypoglycemia, functional bowel disease, anorexia nervosa, obesity and anxiety, "and a host of others where the symptomatology seems to come in when you end up with the absence of a drug."

Doctors are beginning to see a certain pattern of drug use and abuse with each of these illnesses. The patterns vary as the medical community changes its preferred method of prescribing.

Use patterns include: minor tranquillizers for headache; benzodiazepines for stiff neck; alcohol, synthetic narcotics, and anticholinergic agents for functional bowel disorders; benzodiazepines and alcohol for atypical chest pain.

Dr Wright observed: "We are beginning to see individuals entering the pain-pill cycle. Those who work with these people are beginning to wonder if a conditioning effect is beginning to take place.

"The individuals develop symptoms, see the doctor, and the doctor says 'take this.' It works, and it has also the effect of treating their dysphoric moods in any number of the vicissitudes of life.

"The individual cycles build to the point where there is a rebound effect when they are taken off the drug; overreactivity occurs, anxiety levels increase, the symptoms return, and they are back to the doctor for more medication."

Wright: synergistic medication.

For the low-risk individual, the medication confers a benefit. On the other hand, the early alcoholic, or those at risk of chemical dependency, or those who have a well established pattern of drug use, are also being treated with drugs.

Dr Wright said that doctors and other health care professionals are in an invidious position because for one group the drugs are very useful and can reduce morbidity, while for the other group the drugs could increase morbidity.

"The way to tell the difference between the two is the sound practice of medicine," Dr Wright believes. The doctor should check how long a patient has been on a particular medication, whether the usage level has increased, and — the bottom line — whether a prescription is issued every time the patient comes in.

Unbelievable situations are arising: an individual cannot do his job properly, but he has a legitimate illness and a legitimate prescription. Others are being stopped by police because their driving is obviously impaired, but they have legitimate prescriptions.

Dr Wright: "My suggestion would be that if an individual is impaired on the job as a result of drug effects, then it does not matter if the drug is acquired by a prescription, is bought at the water fountain, or is legally acquired, like alcohol, and used on the job.

"Being drug impaired is being drug impaired, and if individuals cannot do their job as a result of drug dependence, they should be advised of that fact. It is only by this kind of approach we are going to uncover the small sub-set of patients who have a chemical dependence problem."

Dr Wright said one reason for what he called "iatrogenic addiction" is that often the doctor does not have complete information and goes by what the patient tells him.

He said it took a long time to learn about the effects of alcohol on the individual. Today, "we do not know, but we are trying to find out, what the effects are of multiple agents — alcohol plus minor tranquillizers, plus semi-synthetic narcotics, plus central nervous system stimulants — over time will be on the individual."

The answers are not yet in. And if a doctor has patients with multiple-use patterns, rehabilitation will be difficult.

"About four weeks into rehabilitation they are going to develop either headaches, back or neck pain, or some kind of painful syndrome. They will be very real and intense and these people will almost invariably return to drug use unless you are able to provide for them alternative methods about how to cope."

Attention must be paid to program evaluation

By Eleanor Lebourdais

RICHMOND, BC — To be effective, clinicians "have to be pushed to the brink of being challenged without going psychotic," William Filstead told the 1982 Pacific Western Conference on Alcohol Problems here.

Dr Filstead said more attention should be paid to training of clinicians, with more "creative reflectivity" in the apprentice approach. Trainees should evaluate their own effectiveness with various clinical skills, he said, adding that clinicians do not have to excell in all clinical skills.

Trainees should be encouraged to question or challenge a therapist.

"If you can't be challenged to think about what you do, you can't do what you do very effectively."

Dr Filstead is director of research and evaluation at the Lutheran Centre for Substance Abuse, Lutheran General Medical Centre, Park Ridge, Illinois and a leading educator in the field.

"If you accept the premise that alcoholics are not alike, all misuse is not abuse, and not all abuse is dependency, a facility must begin identifying who they can and can't work with."

He suggested it is unprofessional to accept everybody; treatment facilities must better define what their limits are. "You can still do something for everybody by saying 'we can't do anything for you'."

Dr Filstead: "It's important for treatment facilities to realize the seriousness of some psychiatric complications that can overlie, as well as be in addition to, alcohol abuse."

He questioned whether treating the substance abuse will result in improvements in other areas of the person's life. There may be fewer problems related to the substance abuse itself, "but this does not necessarily mean the person feels better, looks good, can get a job, and understands all the basic social skills of how to get along."

He said most alcoholism facilities prefer to focus on drinking behavior, and don't spend much time on other psycho-social functions and skills.

Dr Filstead urged greater attention to program evaluation as part of the patient's clinical record. This evaluation, he said, should start with "baseline characteristics": what the patient thinks about himself, what the therapist may perceive about the clinical situation, what family members may say. At discharge, it is important to get a sense of what has happened during the course of treatment, to what extent both patient and therapist feel progress has been made, and what each perceives as progress.

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The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Ballpark beer is ok for baseball but football fans are different

"Baseball is just not baseball without beer," said Wayne Howell in his column on beer now being available at Exhibition Stadium, Toronto (**The Journal**, Sept). Would we argue the same for beer with football?

I personally don't think so. For one thing the games are different; for another the fans respond differently. Football is controlled physical violence. Each team applies maximum physical force to immobilize the other — 'get the quarterback!'

Baseball, on the other hand, is a pussycat. It pantomimes violence — Billy Martin kicking dirt on the umpire's shoes. It takes a home-run or a nifty double-play to arouse Toronto baseball fans from their customary narcolepsy. Football fans, on the other hand, are larger than life, adrenalin pumping, and chanting.

Beer also affects the football fan more than the baseball fan, judging by the report by *The Toronto Star* on the September 10 game when Toronto Argonauts defeated the Hamilton Tiger-Cats. *The Star* said ". . . football-crazed fans brawled in the stands at Exhibition Stadium last night . . . several dozen fans didn't have to worry about getting home — they ended up in police cells charged with a variety of liquor-related offences."

I was there. Ten rows behind me, it took three policemen to stop a vicious, bloody fight, (one of several) which erupted between a "beergoisie" in his 20s (like the 'glamorous' young people featured on beer commercials) and a 40ish, suburban squire. Could this happen at a baseball game? Perhaps, but a football crowd is a king-sized dry martini compared with baseball's pink lady.

Unfortunately, some ingredients of this martini — the young, jittery, "beergoisie" ("Football does it to you," one said. "We've all got a little animal in us") and the 40ish, astringent, suburban squires — don't mix as well as gin and vermouth.

When a "beergoisie" pushes past a "squire" for the sixth or seventh time to get or displace beer, the two move from silent hostility, through snarling and shoving, to bloody combat. The brawls are not just the overflow of adrenalin among jocks. They are ugly confrontations between representatives of disparate social groups.

Toronto has tried for a winning football team for more than 20 years, and even longer to shake its prude image. Beer in the ballpark for Toronto is thirst-quenching emancipation. The September 10 happening may have just been the immediate fallout, a night of jubilation for young Toronto "breaking out."

But experience may show it is prudent, not prudish, at least during the football games, to forgo beer in the ball park. We should be able to rely on local customs and by-laws to protect us against needless physical violence and social confrontation.

I won't go back to the stadium, not during football games. I like watching the fictionalized "beergoisie" on TV — the hang-gliders and wind-surfers who almost walk on water — but I don't relish being bumped by one on his lemming-like trek to get, or displace, more beer.

Andrew T Mathews
Development Officer
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15 Gervais Drive
Don Mills, ON

Exuberant fans crowd the field as football team posts win.

The Journal **welcomes Letters to the Editor: Letters bearing the full name and address of sender may be sent to:** The Journal, **33 Russell Street, Toronto, Canada M5S 2S1.**

Name: MATJE, Kathy **Occ:** Nurse

Cause of Death: Suicide

File: Drugs, War on

Kathy Matje and Lou Kahn: friendship was the first step on an ill-fated journey.

"You said that if what I said was true, I wasn't guilty. What I said was true."

Kathy Matje

By Howard Rahtz*

In Cincinnati, Ohio, as in nearly every part of the United States and other countries around the world, the "war" on drug abuse rages. Kathy Matje's is one episode in the continuing drama. It's also the story of a special police unit operating on the fringes of the law; a court system where justice is held captive to legalistic interpretations; and a jail facility where, despite her forewarning of her intent, a young woman takes her own life.

The story begins in November 1978, in the Cincinnati General Hospital emergency ward where Kathy Matje worked as a clerk to support herself through nursing school. A man named Lou Kahn was brought in with gunshot wounds; over his two-week stay, he and Ms Matje developed a friendship.

This was the first step on an ill-fated journey for Ms Matje. It ended with her death, at the same hospital, nearly three years later. Ms Matje didn't know Lou Kahn was a paid informant for RENU, Regional Enforcement Narcotics Unit.

Formed in Hamilton County, OH, in 1974, and originally supported through federal law enforcement funds, the unit now operates under a special levy passed by Hamilton County voters. RENU agents are police officers from several local jurisdictions, working under the Hamilton County prosecutor's office.

RENU's special mission is the "big-time pusher," the organized drug trafficker, in Hamilton County. According to funding documents, the unit's primary objective is "apprehension of individuals supplying the community with illegal drugs."

Romantically involved

Following Lou Kahn's discharge from hospital, he and Ms Matje dated four or five times, but she was involved in another relationship, so Mr Kahn disappeared from her life.

In February 1981, more than two years later, Ms Matje and Mr Kahn met again and began to see each other regularly, becoming romantically and sexually involved.

The relationship soon began to change, however. Mr Kahn became "more abusive" and "less of a boyfriend," she said later. He asked her to get drugs for him, sometimes calling her at the hospital where she was now employed as a nurse. She resisted, indicating she could lose her nursing licence. Her co-workers recall she was upset by these calls.

Sometime before March 25, 1981, Mr Kahn left approximately 100 quaaludes at Ms Matje's apartment. He told her he had to go somewhere and didn't want to take them with him. While uncomfortable with the idea, she agreed to hold the pills.

On March 25, after midnight, Mr Kahn telephoned and asked if he could stop by and pick up his quaaludes. Ms Matje agreed. When Mr Kahn arrived, another man was with him. That man was Rick Taylor, a RENU agent.

There are two versions of what happened next.

Rick Taylor testified that Ms Matje gave him two bags of quaaludes, and he gave her $225. Ms Matje testified that Lou Kahn and Mr Taylor exchanged the pills and money, despite Mr Taylor's attempts to involve her by asking her the price of the pills and attempting to give her the money. In both cases, she refused to participate, explaining the pills belonged to Mr Kahn.

This episode is the basis of the drug trafficking charge against Ms Matje for which she was given a three-year jail sentence.

Two versions

A second, nearly identical, incident occurred on April 16, 1981. Just back from a vacation in Birmingham, Al, Ms Matje received a 'phone call from Lou Kahn. He asked if he could pick up the rest of the quaaludes. She agreed, but asked him to stop and buy her a can of Solarcane (a sunburn treatment) as she was badly sunburned following her vacation.

Mr Kahn again arrived with Rick Taylor. This time six quaaludes were exchanged for the Solarcane. Again there are two versions of the exchange.

Agent Taylor testified he received six quaaludes from Ms Matje and, in return, handed her the sunburn preparation.

Ms Matje testified that as soon as the men arrived, she and Mr Kahn went into the bedroom where he sprayed her back with the medication, and then asked her where the pills were. She did not see the exchange take place.

This trade was the basis for a second charge against Ms Matje, for which she was ultimately sentenced to one year in jail, concurrent with the three-year sentence on the first charge.

A few weeks after the second incident, Ms Matje and Mr Kahn ended their relationship by mutual agreement. On July 25, 1981, Kathy Matje was arrested and charged with two counts of drug trafficking. On November 20, she went to trial in Hamilton County Court of Common Pleas before Judge Peter Outcalt.

She waived a jury trial, and her attorney, David Parker, raised the defence of entrapment. In support of this defence, Mr Parker called on Lou Kahn to testify, but was unable to locate him.

Mr Parker was, however, able to locate other young women who testified to remarkably similar experiences with Lou Kahn. They had met him, become friends, and, in some cases, sexually intimate. They had also become involved in a drug sale of some sort as a result of their relationship with him, and then, although none had had any previous involvement with the law, they found themselves arrested by RENU on drug charges.

Entrapment ruled out

Mr Parker's contention, based on Kathy Matje's testimony, that she was entrapped and, indeed, was one of a series of women, mostly nurses, similarly entrapped, was disputed by the prosecutor.

The prosecutor argued the cases of the other women were irrelevant. He stated, based on the testimony of Mr Taylor Ms Matje had willingly involved herself by agreeing to keep the drugs at her apartment, and that based on a recent Supreme Court ruling, entrapment was not a valid defence in this case.

After considering the evidence, Judge Outcalt said he believed Ms Matje was not entrapped in the legal sense.

What had happened during the two incidents in question? Judge Outcalt had to choose either Ms Matje's version and find her innocent, or accept the testimony of RENU agent Taylor and find her guilty.

The judge found Kathy Matje guilty on both counts. Although prior to sentencing, defence attorney Parker had asked for consideration of the fact Ms Matje had no previous record, and was a nurse with a good job, Judge Outcalt had no option. Ohio law calls for a mandatory three-year sentence on the first count. Ms Matje was sentenced to three years on the first count and a concurrent one-year term on the second.

But Ms Matje decided she would take her

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Entrapment: a complicated issue

A legal comment on the question of entrapment in Canada and the United States — page 10

NEWS AND COMMENT

She told the deputy she'd commit suicide

(from page 9)

life, rather than go to prison. She did not keep that a secret. Judge Outcalt set a $100,000 bond, pending a three-week stay of sentence, on the basis that she would be safer in jail.

Her attorney told the deputy who escorted her to jail that she intended to commit suicide and that she might have drugs hidden in her diaphragm. This information was passed on to jail personnel, who say Ms Matje was stripped and searched.

Appeared ill

Reportedly, she refused to remove her diaphragm and was placed in a cell shortly before noon. Just before midnight, jail personnel noticed she appeared ill. At 1 am in Cincinnati General Hospital, she died.

On March 31, 1982, Kathy Matje's family filed a $4 million lawsuit in federal court in Cincinnati against officials of RENU and of the Hamilton County jail. The suit charges Ms Matje's civil rights were violated by unconstitutional "use of sexual advances and physical threats." The suit also charges that Hamilton County jail officials "acted with deliberate and callous disregard for the serious medical needs of Ms Matje."

In response to the Matje suit, Hamilton County officials have filed a suit against Lou Kahn. The suit claims any injuries to Ms Matje "if at all, were solely because of the actions of defendant Kahn." Judgement against Mr Kahn, in an unspecified amount, is asked.

Since the Matje suit was filed, other similar cases have come to light. On April 24, 1982, the *Cincinnati Enquirer* reported that a RENU informant named James Barnett, who like Lou Kahn worked under the direction of Rick Taylor, had been sexually intimate with women later charged with drug trafficking. In both cases the women insisted they had had no involvement with selling of drugs prior to their relationships with Barnett.

In May 1982, a Cincinnati man, named Dwayne Ballou, filed suit in Hamilton County Common Pleas Court claiming he was entrapped on a drug charge in the fall of 1981. The charge stemmed from a meeting in a singles bar with a woman Mr Ballou knew only as "Mona," who implied sexual favors would be given to Mr Ballou in return for quaaludes.

According to documents filed by both Mr Ballou and his mother, he initially refused, and only after several phone calls to his parent's home where he lived, did he agree to get quaaludes for "Mona." He was arrested, pled guilty to a reduced charge, and received probation. He decided to file suit after discovering "Mona" was Romona Murry, an assistant prosecutor with the City of Cincinnati.

Informant terminated

Hamilton County prosecutor Simon Leis, whose office oversees RENU, states that an investigation into Lou Kahn's activities was completed by his office in the summer of 1981, and as a result of the investigation, Kahn was terminated as an informant. He refuses to comment on any other aspect of the case, including the reasons for proceding against Kathy Matje in November of 1981, despite knowledge of Mr Kahn's methods.

On May 24, 1982, Mr Kahn was sentenced to 1-10 years for attempted manufacturing of drugs, a charge filed in February of 1979. Lou Kahn was ordered held in Hamilton County Jail until officials could arrange a correctional placement outside the area for his safety.

Howard Rahtz, a freelance writer, is also executive director of the Alcoholism Council of Cincinnati.

Entrapment: a complicated issue

Leaving aside the author's obvious sympathies, would Kathy Matje have been convicted of drug trafficking in Canada? The issue of entrapment was most recently considered by the Supreme Court of Canada in the case of Victor Amato, a North Vancouver hairdresser who appealed his conviction for cocaine trafficking.

Over a period of two-and-a-half months, Mr Amato was repeatedly contacted first by a police informer and subsequently by an undercover officer with requests for drugs. The almost daily contacts included telephone calls and visits to both his home and his place of employment. Mr Amato testified that these persistent requests for drugs were sometimes accompanied by implied threats of physical violence.

In spite of his initial resolve not to become involved in any illegal activity, Mr Amato eventually succumbed to police pressure. Accepting no money or cocaine for himself, Mr Amato procured a small quantity of cocaine for the informer through a friend. He arranged for two additional transactions involving half an ounce and three ounces of cocaine before refusing any further involvement.

In a 5-4 decision, the Court affirmed Mr Amato's conviction. Unfortunately, the decision is disappointing in that it offers no authoritative guidelines for determining what circumstances would be sufficient to constitute entrapment. Only the dissenting opinion discusses the concept of entrapment in detail.

Four of the majority judges agreed with the lower court that the issue of entrapment did not arise on the facts. Furthermore, they specifically expressed no opinion as to whether any relief based on entrapment is available in Canada at all.

Mr Justice Ritchie, in his separate majority opinion, clearly recognized that police entrapment tactics could result in the accused's acquittal. However, the application of this remedy would be extremely narrow, since, in his view, it would apply only to cases in which the police conduct prevented the accused from forming, on his own, the intent to commit the crime. This limitation renders the entrapment issue largely superfluous, since the accused's lack of intent would, in and of itself, be grounds for acquittal.

Mr Justice Estey, speaking for the four dissenting judges, decided that the court could grant relief for entrapment in the form of a stay of prosecution. He argues that the courts have an inherent power to grant such relief in order to prevent the administration of justice from being brought into disrepute.

According to Mr Justice Estey, the question of whether the accused has been entrapped turns primarily on the nature and propriety of the police conduct rather than solely on the accused's predisposition to commit the crime. An accused is entrapped if the police "ensnare" him into committing an offence which they have instigated. Even if entrapped, he said he would only grant a stay of prosecution if the police conduct was "so shocking and outrageous as to bring the administration of justice into disrepute."

The Amato case provided the Supreme Court with an opportunity to settle the confusion surrounding entrapment in Canada. Unfortunately, the decision leaves much to be resolved. Nevertheless, if any relief will be granted, it will be restricted to exceptional circumstances involving clearly shocking police behavior.

The unsettled state of Canadian law makes it difficult to determine whether Kathy Matje would have been convicted in Canada. Indeed the Matje judgment itself, and the above comment on it, reflect a similar confusion in United States jurisprudence. It is impossible to determine whether Ms Matje's conviction was simply a result of the court not believing her testimony and accepting that of the officer. Alternately, the judge might well have accepted part of Ms Matje's testimony, and then held on this factual basis that entrapment did not apply. The difficulty in the Matje case is the separation of the findings of fact and the statements of law. In the highly controversial area of entrapment, such problems are frequent.

The issue of entrapment clearly raises conflicts between the need for effective enforcement and the rights of the individual to be free from police harassment. The conflict and the strong emotions it generates are likely to be with us for some time.

By Rosemary Cairns Way, Richard Coles, and Jasmina Belu, students in the Faculty of Law, University of Western Ontario.

Professionals get swallowed up in their roles

Impaired male physicians not so unusual after all

By Austin Rand

TORONTO — Impaired male physicians are similar, in terms of personality, to other impaired male professionals, says Frederick Glaser, a researcher at the Addiction Research Foundation (ARF.)

"Isolated" is the dominant personality pattern he says.

"Our basic conclusion is that the uniqueness of physician-dependence on drugs and alcohol is probably not correct. Rather, evidence from personality patterns indicates that the impaired physician has a lot in common with other professional people.

"The problem is not the unique professional role of the physician so much as the professional role, period," he said at the annual research day at Clarke Institute of Psychiatry here.

Dr Glaser is chief psychiatrist in the Clinical Institute of the ARF.

In a study carried out with the collaboration of the College of Physicians and Surgeons of Ontario, the Ontario Medical Association, and the Donwood Institute, 35 impaired male physicians were assessed over a three-year period and compared, in terms of personality patterns to 35 impaired professionals matched for age, sex, and race.

An additional comparison group was provided by 836 men admitted to the Clinical Institute for drug and alcohol problems. These men were so distinct from the doctors in terms of personality patterns that Dr Glaser and his colleagues decided to focus first on comparisons between the doctors and the non-physician professional group.

The impaired non-medical professionals were all college graduates and from professions such as teaching, engineering, dentistry, and chiropracty. Many were high-level business executives.

Both groups had an average age in the mid-forties and roughly 60% of the men in each group were married.

Trait measurement with the Personality Research Form and the Basic Personality Inventory indicated the two groups of professionals were similar.

The impaired doctors were less aggressive, less inclined to express open irritation with people, and inclined to describe themselves in more favorable terms than the other impaired professionals. Other than these three points, however, the groups were hard to tell apart.

When Dr Glaser and his colleagues moved from trait analysis to examining larger-scale personality patterns, or constellations of traits, a difference did emerge between the two groups "but it was much more a difference of degree than a difference of kind."

Of the seven personality patterns distinguished — including "depressive," "defensive," "extroverted,""isolated,""paranoid" "sociopathic," and "atypic," only one — "isolated" — collected disproportionate numbers of subjects.

In fact, 31% of the impaired non-medical professionals were "isolates" and 57% of the impaired physicians fell in that category.

When the physicians were divided into family practitioners and specialists, 48% of the former and 83% of the latter turned out to have an "isolated" personality pattern.

"Roughly speaking," said Dr Glaser, "based on this study, the more professionalized an individual is, the more likely he is to have this particular pattern."

The pattern is particularly high on scales of denial and social introversion, suggesting, Dr Glaser explained, "that persons having these characteristics do not like to be around other people, prefer solitary activities, and tend to see themselves as not having — nor ever having had — strong feelings."

He suggested the high prevalence of the pattern, particularly among doctors, could be traced to three factors: "First, the selection process that tends to select out people like this; second, what happens to them in the course of their professional education; and third, the contributing effects of the alcohol or drugs being used."

At this point, Dr Glaser said, researchers have no idea how much each factor contributes to the development of the "isolated" pattern.

Regarding the first two factors, he noted that a study of personality patterns among University of Toronto undergraduates had found that pre-med students more than other groups showed a leaning towards "isolation."

What is it about the professional role itself that fosters the emergence of the pattern?

"Professional roles, whether medical or otherwise, are characterized by requirements of commitment early in life and of a prolonged period of training, with the potential subordination of other life-goals to the achievement of professional competence," Dr Glaser noted.

While most professionals tolerate the demands fairly well, he added, some get swallowed up by their professional role.

"Our clinical experience in dealing with many of these people was that they were people who appeared to have allowed their professional role to occupy their entire lives, to the detriment of other, more sociable roles that they might play."

Dr Glaser said that this seemed to work for a while for the professionals in the study — perhaps for 20 years or until the mid-to-late forties — "but it seems that eventually it becomes clear to them that this exclusive occupancy of the professional role is not going to provide all the gratifications that they are seeking. When that becomes apparent, they have very few skills to gratify themselves in other ways, particularly interpersonally. They turn to alcohol and drugs as a simple and readily available way of gratifying themselves that doesn't require interpersonal skill."

Illicit drug demand is target of tri-agency plan

By Thomas Land

VIENNA — Three specialist organizations of the United Nations concerned with health, education, and labor will help the worried public health administrators of Western Europe and North America in a program for the rehabilitation of young drug addicts.

Funded largely by Western development-aid capital, the three agencies have, to date, concentrated their efforts in the poorest regions of the world.

Their joint strategy is being developed in a series of specialist meetings in Vienna, opened by Tamar Oppenheimer, the Canadian official recently appointed director of the UN Division of Narcotic Drugs. The action-oriented scheme, endorsed by the Economic and Social Council and approved by the General Assembly, widens the five-year-old global policy initiated in Nordic Europe to fight drug addiction by eliminating the sources of supply.

Mrs Oppenheimer — a key figure in the third UN congress in Stockholm on the prevention of crime and treatment of offenders — explains: "Demand is an important aspect of the complex problem of drug abuse. Unless the illicit demand can be reduced, efforts to reduce illicit supply will be frustrated."

The Nordic Council, representing Denmark, Finland, Sweden, Norway, and Iceland, declared its policy of releasing development aid funds to finance crop substitution in the opium-growing Asian countries in 1977, when their own combined population of drug addicts exceeded the 10,000 mark. Many countries including Australia, Britain, Canada, and the United States joined the Nordic initiative.

It led to vast, and initially successful, UN-backed projects in Thailand, Burma, and elsewhere, intended to persuade local peasants to switch from opium poppies to alternative crops such as coffee and kidney beans.

The moment appeared opportune, since the notorious French Connection, supplying Asian heroin to West European and North American addicts, had just been dismantled. Even the weather was to support the scheme by ruining several successive opium crops in the Golden Triangle of Asia, the world's principal source of illicit heroin supplies.

So, the flexible international crime syndicates looked elsewhere to meet the Western demand for heroin. They found ideal conditions for their trade in war-torn Iran and Afghanistan as well as Pakistan. And the vacuum left behind by the French Connection was quickly filled by several rival smuggling organizations.

One of the largest has just been broken, after many arrests in France, Canada, and the US. But the specialists meeting in the Austrian capital foresee no slackening in the trade — especially now that recurring favorable weather conditions have led to the second-successive, bumper opium harvest in the Golden Triangle.

Meanwhile illicit demand for drugs has widened in the West. The number of addicts, mainly young people, in the 10-nation European Community alone, is estimated at 200,000. This compares with about 600,000 in the US. Many specialists blame the trend on poor economic conditions, causing growing youth unemployment, as well as cuts in the national education and public health budgets.

Hence the expansion of the Nordic initiative to confront the heroin trade, on both the production and the consumption fronts. "When demand is maintained," Mrs Oppenheimer comments, "the elimination of one source of supply will be offset by the emergence of others."

The participation of the UN Educational, Scientific and Cultural Organization, the International Labour Office, and the World Health Organization will contribute funds and specialist knowledge in the areas where help is most needed by addicts in the recession-bound West.

The joint policy may even persuade some governments to reconsider social spending policies. Mrs Oppenheimer is optimistic. "Education, treatment, and rehabilitation," she observes, "are key elements in the prevention and reduction of drug abuse."

UK radio program exposes widespread use of benzodiazepines

LONDON — Public concern about the number of people who want to overcome their addiction to benzodiazepines has prompted Release, the national drugs and legal advisory service, to publish a self-help pamphlet "Trouble With Tranquillizers."

A recent radio show on drug abuse, which intended to discuss heroin, cannabis; and glue, ended up concentrating entirely on benzodiazepines because of the overwhelmingly number of calls, mainly from women who wanted to come off these drugs.

The pamphlet outlines a 12-point plan which suggests weaning oneself off the drugs gradually, and advocates three weeks as the minimum withdrawal period. An estimated 100,000 people in Britain are dependent on tranquillizers.

Wine especially is losing its popularity

Alcohol consumption in France is dropping

By Lynn Payer

PARIS — A hostess who entertains frequently in both Paris and New York has observed that while United States guests request wine as an aperitif, French guests are likely to want whiskey.

Wine consumption has, in fact, dropped precipitously in France.

A 1981 study by the French National Institute of Agricultural Research and the National Office of Table Wines showed that per-capita wine consumption has dropped to 90 litres from 120 litres in 1964. While beer and other alcoholic beverage consumption has increased, almost making up the difference, France remains one of the few countries in the world where total alcohol consumption is dropping slightly.

The reason may be simply that France was at saturation point. In spite of the drop, the country has one of the highest per-capita alcohol consumption levels in the world.

The 1981 report attributes the drop in wine consumption in part to television, which has reduced the importance of the neighborhood bistro and, in part, to changing occupational patterns. Traditionally, farm workers could, and often did, consume several litres of wine a day; such consumption is unthinkable for factory workers.

But "warriors" in the fight against alcoholism would like to believe their educational campaigns have had something to do with the drop. "The idea that alcohol can be dangerous is now accepted in France," said Jacques Godard of the Comite National de Defense Contre l'Alcoolisme (CNDCA).

Some progress made

Dr Godard cited several recent small victories in the French fight against alcoholism. All hospitals are now equipped to treat alcoholism, whereas a few years ago severe alcoholics were sent to psychiatric hospitals or received symptomatic treatment for whatever had put them in the hospital, but nothing for their alcoholism. Ten years ago there were no Centres d'Hygiene Alimentaire, where alcoholism is both detected and treated. Now there are over 200.

Even Ricard, the *pastis* manufacturer often locked in bitter battles with the CNDCA and other anti-alcoholism forces because of its advertising practices, has come out with an alcohol-free pastis. The new drink, with a licorice base, was welcomed by the CNDCA, which has based part of its campaign on greater availability of, and lower prices for, non-alcoholi beverages.

Former president Valery Giscard d'Estaing also delighted anti-alcoholism forces when he spoke at the Entretiens de Bichat, the annual French meeting for doctors, denouncing the effects of alcoholism on the country.

School children

He also commissioned Jean Bernard, MD, a cancer specialist, to head a commission on alcoholism. Dr Bernard's report was subsequently issued with 100 recommendations, ranging from more water fountains through reduction of the surface size of vineyards, to treatment of alcoholics and the production of wines with a lower degree of alcohol. One of the recommendations has been acted upon: school children under 14 years are no longer allowed to have wine or beer with their meals at school.

As for the rest of the report: "They said 'bravo' and stuck it in a drawer," said Dr Godard.

Whether Mr Giscard d'Estaing would have done more remains hypothetical, because he was defeated in the election by Socialist candidate Francois Mitterand.

"Something's happening that we're not used to in France," said Dr Godard. "All the high-level civil servants are being replaced."

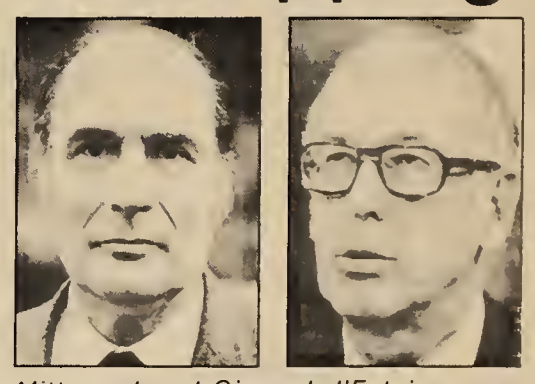
Between the non-violent revolution and the pressing economic problems facing Mr Mitterand, not much has happened in terms of alcohol problems since the new president took office.

One thing troubling Dr Godard is that the new minister of health is one of the handful of Communists appointed by Mr Mitterand, and Communists in France follow the traditional Communist line on alcoholism: once workers' lives are made more bearable, alcoholism melts away.

The CNDCA wrote to all candidates before the election asking their views about alcoholism, and all responded, a fact that already signals a departure in French thinking on alcoholism.

George Marchais, the Communist candidate, however, took strong exception to one aspect of the CNDCA's (and the Bernard report's) recommendations: that the acreage given over to vineyards should be reduced, particularly in areas where the quality of the wines produced was not exceptional.

"To end alcoholism by a massive uprooting of vines," Mr Marchais wrote, "seems to me an argument as specious as that which says that to conquer obesity we should end the production of sugar, or to efficiently attack atherosclerosis to kill our animals . . . I am categorically opposed to the reduction in wine acreage that you are proposing . . . the grapevine represents an important wealth of the country."



Mitterand and Giscard d'Estaing: non violent revolution and economic troubles

Vineyards, suggested a commission on alcoholism, should be reduced in surface size. But, they said 'bravo' and 'stuck the report in the drawer.'

Export markets dwindle

That reduction may be coming, nevertheless. With French wine consumption dropping drastically, France must find new export markets, and the country is facing increasing competition from Italy, Spain, and even California. Recent reports suggest the increase in US wine consumption is slowing because of the recession, and, while the temporary strength of the US dollar favors imported wines over Californian wines, this could be temporary. With many French people making their living from alcohol, such considerations are of major economic importance, said Dr Godard.

New provisions of the European Economic community — originally scheduled to go into effect on September 1 but delayed because legislation for their implementation had not been passed — guarantee price supports for excess wine that is distilled.

While wine-growers in the south of France were generally favorable to the provisions, they planned to demonstrate their general unhappiness with the situation on July 31 and August 1, the day the majority of French people leave for their vacations, by letting motorists go free through super-highway toll-booths, at the same time distributing literature explaining the wine-growers' position.

NEWS

Missouri U program is three years old

Med student alcohol course has surprise result

By Harvey McConnell

WASHINGTON — A three-year-old program to educate University of Missouri medical students about alcoholics and alcoholism has already had an unexpected payoff.

"That payoff for me has been the inordinate number of calls and requests we get from students who have gone through our program and who are asking for information — not for patients, but for family members or friends," said Kristi Roberts, PhD, one of the founders of the program.

"I think we can demonstrate we are making an impact."

Such a payoff could not be anticipated when Dr Roberts, program coordinator of the Alcoholism Unit, Harry S Truman Memorial Veterans Hospital, Columbus, MO, and her colleagues started the program in the department of community medicine in 1979.

Although there are several recovering alcoholics on the faculty, the general attitude at the medical school was that alcoholism was something that did not need to be covered in the academic curriculum.

When members of the family practice house-staff were asked what could be done to interest them in alcoholism, there was little response. In some ways, in fact, it was quite the opposite, said Dr Roberts.

"They said they had read up on it, they knew about detoxification protocols, and they got quite a lot of information on alcoholic patients on medical rotations. But, what they did say they felt was a significant problem, and one which they were not sure was reversible, was that they did not like alcoholics.

"One doctor told me 'I don't want to touch an alcoholic. They make me sick'."

The current program includes lecture time during the first two years of medical school, and, in the third and fourth year, up to 12 hours in the alcoholism unit, which is affiliated with the medical school.

More than 50% of the students taking part in the program have an alcoholism problem in their own families. These students spend additional time with a counsellor on staff who has the same problem "and it is really a therapeutic environment for them," Dr Roberts added.

She said when students enter the program, a majority consistently believe such statements as: alcoholism is related to amount of alcohol consumed at one time; most alcoholics have underlying symptoms of a personality or mental disorder; or alcoholics who fall off the wagon more than four times can't be treated. The statements appear on a questionnaire.

The students take the test again when they finish the program and their attitudes appear to change, although Dr Roberts admits it may be that they know what she and her colleagues want to hear.

The program includes a session with a doctor who is a recovering alcoholic. The students also see patients who want treatment, and those who don't, work with the therapist, and attend one AA (Alcoholics Anonymous) meeting.

Dr Roberts: "What we are doing at the University of Missouri is not as much scientific as trying to get people interested in alcoholism in any possible way."

The fact former students now ask for help and information persuades program organizers they are meeting that goal.

Pioneer doc to problem drinkers lends name to treatment centre

CALGARY — A man who 'restored dignity to the lives of reforming alcoholics' has been honored in Alberta.

David Lander — "Doctor Dave" to many former problem drinkers — has lent his name to the newest centre in Alberta for the residential treatment of drug and alcohol abusers: a 50-bed motel-style institution at Claresholm, a town of 3,000 about 85 miles south of here.

The David Lander Treatment Centre is the province's latest tribute to a physician who in the 1940s volunteered to attempt the care of chronic alcoholics. Clients were frequently brought to his country general practice, a few miles southwest of Calgary, only after being denied admittance to the big-city hospitals.

Now semi-retired, Dr Lander, 69, still sees a few of those former charges on a clinical or social basis. The alumni of his treatment program, in a small rural hospital, is said to include people of nearly all social, ethnic, religious, and economic backgrounds.

Lander: treating people as human beings.

"Dr Lander exemplifies the finest definition of a dedicated humanitarian," says J. J. Quigley, Calgary, regional director of the Alberta Alcoholism and Drug Abuse Commission.

"His understanding of dignity and worth, and his treatment and care of the whole person, has contributed massively to the relief of human distress and suffering."

Dr Lander's approach to the problem of alcoholism since he started decades ago, has been based on a charitable view of his patients and their predicament.

"If you treat someone like a human being, he reacts accordingly. But if you treat him like an animal . . ."

"An alcoholic has an insatiable hunger for love," Dr Lander says.

Lobbyists shifting DWI laws

WASHINGTON — Pressure by citizen activist groups in the United States has forced significant changes in drunk-driving laws in many states.

Charles Livingston, policy adviser to the recently-formed Presidential Commission on Drunk Driving (**The Journal**, April), said 32 states have now established drunk-driving task forces, and several have improved their drunk-driving laws this year.

He told the annual conference here of the Alcohol and Drug Problems Association of North America the changes have been brought about in response to citizen-activist groups as well as general political pressure.

However, he added, the real problem lies with the relatively small proportion of heavy drinkers — about 7% of the driving population — who account for two-thirds of all alcohol-related, fatal crashes.

"At present, drunk drivers don't believe they're going to get caught. And they are right — they may be stopped only once in a thousand or more trips," Mr Livingston noted.

Even if caught, they assume they won't be convicted or the penalties will be light, and they are correct in many parts of the country. "Thus, the system is not working, the risk of punishment is low, so the deterrent effect is weak."

He said states need to take coordinated action and develop long-term programs for the 1980s to try to deter drunk driving.

The first target should be programs which, in effect, deter the majority of drunk drivers who are never arrested, rather than "treating" the few who are. Emphasis and responsibility for programs must be at the local level.

"People who cause the problem should pay for its solution," Mr Livingston said, and funds obtained through fines and fees can be used to pay local governments for police, prosecutors, treatment programs, and other costs related to drunk driving.

Arrests for drunk driving are on the increase: to more than 1,300,000 in 1981, from 561,000 nationally in 1969.

Mr Livingston said: "There is no question that concern about drunk driving is now greater than ever before and citizens groups deserve a great deal of credit for increasing public awareness of our vulnerability.

Mr Livingston concluded: "There are no silver bullets. Drunk driving is obviously a complex and difficult problem. There are no easy answers, but dedicated volunteers and public officials have shown that significant change is possible.

"Given the current high level of public concern, and our awareness of the specific improvements needed in programs designed to control the problem, it is now feasible — perhaps for the first time — to undertake an effective effort that will save many thousands of lives."

Private sector backing abuse prevention plans

WASHINGTON — Support from private industry in the United States for voluntary drug abuse prevention programs for young people has probably surprised even President Ronald Reagan.

This is the view of Angie Hammock, director of the federal drug abuse prevention program at ACTION, the government's independent volunteer agency (including such groups as the organization formerly known as CUSO).

Ms Hammock told the annual conference of the Alcohol and Drug Abuse Problems Association of North America (ADPA) that the agency has worked closely with US first lady Nancy Reagan, who has a great interest in the problems of drug abuse among young people, especially alcohol and marijuana use.

A number of large US corporations have backed voluntary groups and organizations "and the support in the private sector is far greater than I think even President Reagan imagined in this particular field," Ms Hammock added.

While ACTION's mandate is to work with voluntary agencies, rather than professionals in the field, the agency tries to ensure voluntary groups are not haphazard in their efforts.

Ms Hammock: "We encourage voluntary groups to find out who their professionals are, rather than going out on their own and trying to chip away at this; to find out what is going on in their community and their state, and to try and tap into it. ACTION acts as a catalyst."

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

A Story of Feelings

Number: 510.
Subject Heading: Youth and alcohol, drugs and youth.
Details: 10 min, 16mm, color.
Synopsis: A group of school children draw pictures which come alive. John has a pet cat, Zee. As John grows up he wants to feel different — cool. He starts smoking, then turns to alcohol and many other drugs to feel 'high.' Zee is unhappy and hides whenever John is high. John finally gets help, and Zee and John's friends feel much better.
General Evaluation: Very good. This contemporary, well-produced film was judged to be informative with a clear message likely to produce attitudes opposed to drug abuse. Public broadcast was recommended.
Recommended Use: Beneficial for all audiences.

Marijuana Bulletin: a Research Update

Number: 519
Subject Heading: Drugs and youth, drugs: pharmacology
Details: 17 min., filmstrip, color.
Synopsis: This filmstrip illustrates both human and animal research related to marijuana's effect on reproduction, the brain, personality, and the lungs of marijuana users. However, the filmstrip does acknowledge the need for further research in this area.
General Evaluation: Poor-fair. 2.8 The filmstrip seemed to be stylistically out-dated, boring, and unrealistic.
Recommended Use: If used with its intended audience of teenagers a resource person should be present.

Marijuana: Facts, Myths and Decisions

Number: 518
Subject Heading: Drugs and youth, attitudes, trigger films.
Details: 45 min (total), 4 filmstrips, color.
Synopsis: These filmstrips examine: 1) composition and history of the cannabis plant and its uses, 2) the effect cannabis has on the user, 3) health and legal consequences of cannabis use and 4) interviews and case histories of cannabis users.
General Evaluation: Good. 4.1 These filmstrips were judged to be good teaching aids, likely to produce attitudes opposed to drug use.
Recommended Use: Teenagers, drug users and health professionals are likely to benefit from these filmstrips, providing a resource person is available.

The Stress Mess

Number: 520
Subject Heading: Lifestyle, attitudes, trigger films.
Details: 24 min, 16 mm, color.
Synopsis: This light-hearted film depicts a multi-personality character, Harry, who acts as a stress counsellor to a family. The film shows Harry in scenarios depicting the experience and handling of stress by the family members. Harry provides practical advice on the prevention and reduction of stress.
General Evaluation: Good. 4.1 This contemporary, humorous, well-produced film was judged to be a good teaching aid. General broadcast was recommended.
Recommended Use: Likely to benefit any audience over 15 years of age.

Addictions, Compulsions, and Alternative Highs

Number: 521
Subject Heading: Lifestyle attitudes, attitudes, drug use.
Details: 23 min, 16 mm, color.
Synopsis: Feeling "high" is pleasurable for most people. If they cannot get this feeling from experience such as running, ballet, music, they may turn to other means. Case histories of poly-drug use, alcoholism, gambling and compulsive eating illustrate ways people find to feel good while actually hurting themselves.
General Evaluation: Fair-good. 3.7 This contemporary, informative film could help in decision-making regarding addictions and compulsions. General broadcast was recommended.
Recommended Use: Of benefit to any audience over 15 years of age.

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Information freedom hampers DEA activity

WASHINGTON — The United States Drug Enforcement Administration (DEA) claims the Freedom of Information Act — which allows private individuals to obtain information from government agencies — has affected its operations.

Under the act, an agency can refuse to give out the names of confidential sources, or reveal how it carries out its investigations.

The DEA said they selected 400 cases and asked field agents if use of the act by private individuals had interfered with the agency's work. In 56 of the cases, agents reported investigations were seriously affected.

The agents said one major fear of informants is that their names will be made public. A majority of the agents consider the act inhibits their work, and the DEA claims the majority of requests for information come from "criminal elements."

This publication is indexed in

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Advertising Rates:
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Circulation: 15,094

(Ontario, 11,580; other provinces, 815, USA, 1,979; foreign, 720). Bulk, 3,700; Media, 1,273

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DEPARTMENT

New Books

by RON HALL

National Parents' Movement For Drug Free Youth: P.R.I.D.E. Southeast Drug Conference Proceedings 1980 and 1981

. . . edited by Thomas J. Gleaton, Keith Manatt Schuchard, and Helen W. Moore

Presentations have been selected from the 1980 and 1981 conferences and recent seminars. Speakers have been parents, scientists, physicians, businessmen, and school and law enforcement officials, who are working together to understand and deal with the problems of youthful drug use. The National Parent Resource Institute for Drug Education hopes that the publication of these proceedings will help parents understand the dangers of drug use by youth, and arm parents with the most up-to-date information available. The introduction provides background on the National Parents' Movement for Drug Free Youth, and a later chapter discusses future directions. Several presentations are concerned with marijuana and include: marijuana research 1979; a psychiatrist's perspective; marijuana research and the information gap; marijuana and the media; marijuana, cocaine, and the nature of addiction; marijuana potency and the paraquat controversy; marijuana and the brain; and the impact of marijuana on inflation. Among the other topics addressed are: the impact of the parents' message on White House drug policy, new priorities in legislation and law enforcement, and parents and schools working together.

(Parent Resources and Information on Drug Education, Georgia State University, University Plaza, Atlanta, GA 30303, 1982. 206p.)

Fetal Alcohol Syndrome

Volume II: Human Studies

. . . edited by Ernest L. Abel

This collection of articles is the beginning of a survey of the relationship between alcohol and birth defects. Rather than a general overview of the subject, many of the authors have adopted a critical approach to their subject. Data linking alcohol and obstetric-gynecological problems, patterns of drinking among pregnant women, the clinical and epidemiological evidence linking alcohol consumption and developmental problems, and sleep and EEG anomalies that appear to be characteristic of FAS infants, are examined. The opening chapter discusses "screening" programs for identifying alcohol-related problems among obstetric-gynecological patients. The second chapter reviews the evidence linking alcohol to sexuality and reproductive dysfunction in women. These studies suggest that alcohol consumption can both precipitate obstetrical-gynecological problems and also be a response to such problems. Literature dealing with alcohol consumption during pregnancy is reviewed and a description of the clinical features of alcohol embryopathy is presented. Chapters are also devoted to an overview of methodological and epidemiological issues relevant to FAS research; an in-depth examination of the acute and chronic behavioral effects of an utero exposure to alcohol; and a summary of studies of sleep EEG in newborns of alcoholic mothers.

(CRC Press, 2000 N.W., 24th Street, Boca Raton, FL 33431, 1982. 189 p. $74.00 ISBN 0-8493-6193-1)

Cerebral Deficits in Alcoholism

. . . edited by D. Adrian Wilkinson

These proceedings of the international symposium held in Toronto in March 1979 concentrate on alcohol-related brain damage. Four research areas were covered as follows: (1) the etiology; (2) methodological problems in the study of alcohol-related brain damage; (3) the prevalence; and (4) recovery from alcohol-related brain damage. This volume represents an attempt not only to review some of the recent progress that has been made in this area of research since the publication of *Alcohol, Drugs and Brain Damage* in 1975, but also to offer scientists an opportunity to describe how they see research in this area developing. The opening chapter presents a critique of investigations of brain functions in alcoholics, and is followed by a rationale for a broadly-based examination of alcoholism as a risk factor in cognitive impairments. A review outlines some of the limitations of present knowledge about the prevalence of cerebral disorders in association with alcoholism, based on both neuropsychological and neuroradiological investigations. Other chapters are devoted to accelerated mental aging in alcoholism; reversibility of psychological deficits in alcoholics; possible biological mechanisms for reversible effects of chronic alcoholism on the human central nervous system; and an animal model of alcohol-induced brain damage.

(Addiction Research Foundation, Marketing Services, 33 Russell Street, Toronto, Ontario M5S 2S1, 1982. 159 p. $16.50 ISBN 0-88868-071-6)

Other Books

Occupational Counseling And Referral Systems — Presnell, Lewis F. Utah Alcoholism Foundation, Salt Lake City, 1981. Major types of behavioral-medical problems; factors in problems prevalence; identifiable alcoholism, behavioral case loads experience, and cost factors; in-shop handling of non-stigmatized illnesses and stigmatized behavioral conditions; alcoholism program credits and debits; systems approach to behavioral-medical problems; control system options; control system administration. Appendix, bib. 257p. $14.50.

Controlled Drinking — Heather, Nick, and Roberton, Ian. (jt). Methuen, London, 1981. Disease concept; normal drinking in former alcoholics; loss of control and craving: possible advantages of a controlled drinking treatment goal; controlled drinking treatments; implications. Refs, index. 294p. $33.28.

Endocrinological Aspects of Alcoholism — Messiha, F.S., and Tyner G.S. (jt ed). S. Karger, Basel, 1981. 4th annual conference on alcoholism held in El Paso Texas, Feb 22-23, 1980; neuroendocrinology and neurophysiology; fetal alcohol syndrome; biochemical pharmacology; behavioral pharmacology; amino acids. Index. 232p. $75.

Broken Bottles, Broken Dreams: Understanding And Helping The Children of Alcoholics — Deutsch, Charles. Teachers College Press, New York, 1982. Child at home; child's reaction; child's view of drinking; helping; community strategies for systematic intervention; resources. Appendices, bib, index. 213p. $19.94.

Another Chance: Hope and Health for the Alcoholic Family — Wegscheider, Sharon. Conceptual frame; shared disease; family roles; treatment plan. Appendices, index. 256p. $14.39.

Behavioral Pharmacology of Human Drug Dependence — Thompson, Travis, and Johanson, Chris E. (eds). US Government Printing Office, Washington, 1981. Introduction and overview; historical and personality factors; stimulus control and drug dependence; commonalities and differences among reinforcers; complex schedules and maintenance of drug dependence. (NIDA Research Monograph No 37). 294p.

Opium and the People: Opiate Use In Nineteenth-Century England — Berridge, Virginia, and Edwards, Griffith. St Martin's Press, New York, 1981. Import and cultivation; opium use; restriction; class tensions; professionals and opium; 19th century in relation to the present. Bibliography, figures, illustrations, index, references, tables. 370p. $25.

Drug Control in the Americas — Walker, William O, III. University of New Mexico Press, Albuquerque, 1981. Culture and bureaucracy; politics of drug control; control across the border; patterns of drug control. Appendix, bibliography, index. 287p. $25.

Narcotic Antagonists; Naltrexone Pharmacochemistry and Sustained-Release Preparations — Willette, Robert E., and Barnett, Gene. US Government Printing Office, Washington, 1981. (NIDA Research Monograph No 28). 276p.

Toma Tells It Straight — With Love — Toma, David. Books in Focus, New York, 1981. Dangers of marijuana; drug epidemic; how to know if kids are using drugs, and how to help them stop. 218p. $15.70.

Under the Influence: A Guide to the Myths and Realities of Alcoholism — Milam, James R., and Ketcham, Katherine. Madrona Publishers, Seattle, 1981. Predisposing factors to alcoholism; early, adaptive stage of alcoholism; getting the alcoholic into treatment; guide to treatment; drugs and the alcoholic; late, deteriorative stage of alcoholism. Appendices, index, references, 210p. $10.95.

Alcoholism and Clinical Psychiatry — Solomon, Joel (ed). Plenum Publishing, New York, 1982. Bio-psycho-social perspective in alcoholism; prevention; alcoholism and psychiatry; altered use of social intoxicants after religious conversion; alcoholism and schizophrenia; alcoholism and affective disorders; alcoholism and suicide; hidden psychiatric diagnosis; alcohol and adolescent psychopathology; psychiatric problems of alcoholic women; psychoanalysis; office psychotherapy. Index. 238p. $34.17.

The Chronic Mentally Ill: Treatment, Programs, Systems — Talbott, John A. (ed). Human Sciences Press, New York, 1981. Elements in the successful treatment of the chronic mental patient; successful programs for the chronic mental patient; specialized programs for the chronic mental patient; model service systems. Index. 374p. $32.95.

Frequently Prescribed and Abused Drugs: Their Indications Efficacy, and Rational Prescribing — Cohen, Sidney; Buchwald, Charles; Solomon, Joel; Callaghan, James, and Katz, Daniel (jt ed). Haworth Press, New York, 1982. Drug abuse and the prescribing physician; psychotropic drug interactions; anxiety and psychotropic drug treatment; prescription of stimulants and anorectics; pain; prescription of hypnotic drugs. Refs, index. 80p.

Treatment of Cancer Chemotherapy — Induced Nausea And Vomiting — Poster, Don S; Penta, John S., and Bruno, Salvador, (eds). Masson Publishing, New York, 1981. Basic physiological concepts of nausea and vomiting: studies with delta-9-tetrahydrocannabinol; cannabinoids other than delta-9-tetrahydrocannabinol with antiemetic properties; antiemetic effect of dompamine antagonists; butyrophenones as antiemetics; antiemetic potential of steroids. Index. 235p. $36.11.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

American Society of Criminology — Nov 4-6, Toronto, Ontario. Information: Harvey C. Horowitz and Associates, 10369 Currycomb Court, Columbia, Maryland 21044.

Special Delivery: Innovative Technologies for Education and Treatment — Nov 14-16, Calgary, Alberta. Information: Ms Marge Benner, The Alberta Alcoholism and Drug Abuse Commission (AADAC), 1177 - 11 Ave SW, Calgary, AB, T2R 0G5.

American Public Health Association and Related Organizations 110th Annual Meeting — Aging and Public Health — Nov 14-18, Montreal, Quebec. Information: American Public Health Association, 1015 Fifteenth St, NW, Washington, DC 20005.

Early Recognition and Management of Health Problems in the Workplace — Nov 25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Medical Device Technology in the '80s — Dec 6-8, Toronto, Ontario. Information: Canadian Association of Manufacturers of Medical Devices (CAMMD), 480 Garyray Dr, Toronto, ON M9L 1P8.

36th Annual Convention of the Ontario Psychological Association — Feb 17-19, 1983, Toronto, Ontario. Information: Dr Carl Rubino, Convenor, OPA '83, 1407 Yonge St, Suite 402, Toronto, ON M4T 1Y7.

The Management of Employee Assistance Programs — Feb 23-25, 1983, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

25th Annual Scientific Assembly of the College of Family Physicians of Canada — Apr 24-27, 1983, Toronto, Ontario. Information: George Ackehurst, Director of Communications, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Clinical Criminology: Current Concepts Symposium — Apr 17-29, 1983, Toronto, Ontario. Information: Ms Evon Essue, Conference Secretary, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Medic Canada '83 . . . Toward the Year 2000 — May 29-31, 1983, Edmonton, Alberta. Information: Toby Fay Sykes, Medic Canada '83, 480 Garyray Dr, Toronto, Ontario M9L 1P8.

Fifth World Conference on Smoking and Health — July 10-15, 1983, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, Ontario K1A 0C1.

2nd World Congress on Prison Health Care — Aug 28-31, 1983, Ottawa, Ontario. Information: Congress Secretariat, Medical Services Branch, The Correctional Service of Canada, Ottawa, ON K1A 0P9.

United States

Reality Therapy I - Intensive Weeks — Nov 8-12, Milwaukee, Wisconsin. Information: Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S. 13th St, Milwaukee, WI 53221.

NIAAA Alcohol and Drug Education Conference — Nov 15-16, Portland, Oregon. Information: Paulette Jacome, Project Associate, Polaris Research and Development, Ste 131, World Trade Center, San Francisco, California 94111.

Outcome Evaluation for Alcohol/Drug Treatment Programs — Nov 15-16, Center City, Minnesota. Information: Continuing Education, Box 11, Center City, MN 55012.

American Heart Association — Nov 15-18, Dallas, Texas. Information: D Hafner, 7320 Greenville Ave, Dallas, TX 75231.

An International Perspective on Substance Abuse: The Problem, Its Treatment, and Medical Education — Nov 15-19, Oakland, California. Information: Dr Charles Buchwald, Conference Coordinator, Downstate Medical Center, 450 Clarkson Ave, Box 129, Brooklyn, New York 11203.

Management Information Systems — Nov 17, Center City, Minnesota. Information: Continuing Education, Box 11, Center City, MN 55012.

Alcohol/Drug Dependency and Mental Illness — Nov 30-Dec 1, Center City, Minnesota. Information: Continuing Education, Box 11, Center City, MN 55012.

7th Southeastern Conference on Alcohol and Drug Abuse "SECAD" — Dec 1-5, Atlanta, Georgia. Information: Barbara Turner, Conference Coordinator, "SECAD/7", Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree-Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Shame and Guilt — Dec 2, Center City, Minnesota. Information: Continuing Education, Box 11, Center City, MN 55012.

Women In Treatment — Dec 3, Center City, Minnesota. Information: Continuing Education, Box 11, Center City, MN 55012.

The Borderline Personality - Current Concepts and Approaches — Dec 3, New Hyde Park, New York. Information: Ann Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Workshop on Chemical Dependency and Adolescents — Dec 5-10, Minneapolis, Minnesota. Information: Betty Reynolds, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Intervention-Counselling Techniques — Dec 6-8, Indianapolis, Indiana. Information: Kay F Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Family Program For Professionals — Dec 6-9, Center City, Minnesota. Information: Continuing Education, Box 11, Center City, MN 55012.

Clinical Decision Making in Alcoholism and Drug Abuse — Dec 6-10, New York, New York. Information: Andrew J Gordon, Smithers Alcoholism Treatment and Training Center, St Luke's-Roosevelt Hospital Center, 428 West 59th St, New York, NY 10019.

Pastoral Ministry to Alcoholics and Their Families — Dec 7-9, Center City, Minnesota. Information: Continuing Education, Box 11, Center City, MN 55012.

9th Winter Midwest Institute of Alcohol Studies — Jan 9-14, 1983, Kalamazoo, Michigan. Information: Margaret M Bernhard, Division of Continuing Education, Western Michigan University, Kalamazoo, MI 49008.

International Symposium on the Psychobiology of Alcoholism — Jan 16-18, 1983, Beverly Hills, California. Information: Health Sciences, UCLA Extension, PO Box 24901, Los Angeles, CA 90024.

Alcoholism — The Search for the Sources — Jan 19-21, 1983, Raleigh, North Carolina. Information: Sparky Carpenter, Information Specialist, PO Box 6507, Raleigh, NC 27628.

Family Dynamics of Alcohol/Drug Dependence — Feb 14-16, 1983, Indianapolis, Indiana. Information: Kay F Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

1983-84 Chemical Dependency And Family Intimacy Training Project — Feb 1983-Feb 1984, Minneapolis, Minnesota. Information: CDFI Training Project, Program in Human Sexuality, University of Minnesota, 2630 University Ave SE, Minneapolis, MN 55414.

Counselling Theories and Techniques — Mar 21-23, 1983, Indianapolis, Indiana. Information: Kay F Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Ruth Fox Course for Physicians — Apr 14, 1983, Houston, Texas. Information: Claire Osman, Course Coordinator, American Medical Society on Alcoholism, 733 Third Ave, New York, New York 10017.

National Alcoholism Forum, "Marketing the Message" — Apr 14-17, 1983, Houston, Texas. Information: Louisa Macpherson, Forum Coordinator, National Council on Alcoholism, 733 Third Ave, Ste 1405, New York, New York 10017.

7th World Conference of Therapeutic Communities — May 8-13, 1983, Chicago, Illinois. Information: Donna Gleixner, Gateway Houses Foundation Inc, 624 S Michigan Ave, Chicago, IL 60605.

Abroad

International Conference on Khat — The Health and Socio-Economic Aspects of Khat Use — Jan 17-21, 1983, Antananarivo, Madagascar. Information: Archer Tongue, Director, International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

NSAD 10th Biennial Summer School on Alcohol, Drugs and Chemical Dependency — Jan 26-28, 1983, Wellington, New Zealand. Information: Bursar, Barbara Mills, NSAD, PO Box 1642, Wellington, New Zealand.

World Conference on Alcoholism — Feb 26-Mar 6, 1983, London, England. Information: Pat Fields, Charter Medical Corp, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, Georgia, 30342.

World Symposium on Acupuncture — May 26-29, 1983, Bombay, India. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

2nd European Symposium of Acupuncture — June 3-5, 1983, Stockholm, Sweden. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

7th World Congress of Psychiatry — July 11-16, 1983, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, 1983, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

8th World Congress of Acupuncture — Oct 12-16, 1983, Seoul, Korea. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, 1983, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, PR 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, 1983, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, 1983, Tel Aviv, Israel. Information: Judge Amnon Carmi, Chairman, Organizing Committee, 2nd International Congress on Drugs and Alcohol, PO Box 394, Tel Aviv 61003, Israel.

Sex and drugs: exploring the links

By Richard Starks

Interest in psychoactive drugs and sexuality, says David Smith MD, is as old as civilization itself, yet both fields are relatively new as scientific disciplines. It is for this reason, perhaps, that both fields are also widely misunderstood and subject to arbitrary judgement by society and the law — a judgement that can, for example, label some drugs and sexual practices as inherently "evil," while happily accepting others that, scientifically speaking, are clearly harmful, perhaps even fatal.

Last year, a conference was held in San Francisco to dispel some of the misunderstandings and to explore some of the links between the two fields. Its success, says Dr Smith, came largely from the fact that it treated the fields not as two separate entities, but as a single discipline made up of two overlapping parts.

The conference, titled Sexological Aspects of Substance Use and Abuse, was organized by the Haight-Ashbury Free Medical Clinic (of which Dr Smith is the founder and medical director) and the Institute for the Advanced Study of Human Sexuality. And the result — this year — is the publication of a selected number of the conference's papers in a double issue of the *Journal of Psychoactive Drugs* (Volume 14, Numbers 1-2).*

Unpredictable factors

As Dr Smith, also guest editor of the journal's double issue, says in an introduction, sexual behavior and psychoactive drug use are both subject to so many unpredictable factors that an attempt to bring some order to them may only add to the "simplistic reductionism" common in a lot of medical literature on psychoactive drugs, which portrays substances as either "good or bad, legal or illegal, socially approved or prohibited, recreational or medicinal."

It just doesn't work that way. The relationship between, say, heroin and sexual functioning is, as one of the papers says, a "complex interaction of pharmacological, physical, psychological, and sociological variables." It can not be easily drawn.

Nevertheless, some general conclusions can be reached. For example, drug abuse is a frequent cause of sexual dysfunction; and sexual dysfunction is a frequent cause of drug abuse.

It was the growing awareness of this chicken-and-egg inter-relationship that led to the conference in the first place. And it is borne out by many of the case studies reported at the conference and published in the journal's double issue.

'Blame it on the boogie'

The case of a 32-year-old black male is representative. He sought treatment for his high level of heroin addiction. He had no sexual problems at all, he said, but later he admitted to a near-complete ejaculatory and erectile failure. This didn't concern him, though, because if he couldn't perform sexually, he'd simply cite the heroin, telling his "old lady" that she should "blame it on the boogie."

However, when he detoxified from heroin, he was troubled by premature ejaculation. And that did bother him, because without the heroin, he had nothing to blame but himself. It was for this reason that he'd started taking heroin in the first place.

Say the authors of the paper: "The client was unaware that premature ejaculation (is) a treatable condition. He was not aware that more constructive methods (are) available for the management of this problem than self-medicating it with heroin."

In another case, the drug-sexuality link shows up in a different way. A 30-year-old white male began taking drugs when he tried snorting cocaine in a social-recreational setting. He found it increased both his sexual desire and performance, so he moved on to cocaine freebase and increased the dosage.

However, he then became involved in homosexual marathons at gay bath-houses, which he found distressing, since he considered himself to be solely heterosexual. He began self-medicating his distress by smoking Persian heroin. This eliminated his anxiety, but it also eliminated his sexual desire and his ability to ejaculate or sustain an erection.

When he sought treatment, it was for both drug dependence and for depression caused by his sexual confusion.

"What we've found," says Dr Smith, "is that only about 5% of the people who seek drug counselling express any sexual concerns. But under routine questioning, as many as 40% admit to sexual concerns."

Multiplier effect

Last year's conference was the first national attempt in the United States to publicize this drug sex overlap, but already it is having an effect. This month, a second conference will be held, co-sponsored by the University of California at Los Angeles. "We're seeing a multiplier effect. We're very pleased; it's good to have this kind of recognition from a major institution," says Dr Smith.

A third conference is tentatively planned for 1983, and Dr Smith is optimistic that this is just the beginning. He hopes other regional conferences will follow, as more and more drug counsellors and sex therapists realize just how much their disciplines intertwine.

At the moment, there is little recognition of this fact. Each of the two disciplines is largely uninformed about the other, and there is not much dialogue between them. But slowly the two sides are growing closer together.

Dr Smith hopes the catalyst that will unite them is the double issue of the Journal of Psychoactive Drugs, and the 20 articles or papers it contains. These papers can be used as a springboard for discussion at regional conferences since they are national in outlook and cover a broad range of sex-drug topics, he says.

In their own words

In the papers the case histories stand out most clearly — mainly because they're human and because the subjects are allowed to talk in their own words. One client reports: "On barbs, I pulled a train with seven Hell's Angels. I got plugged everywhere and loved it."

There are also touches of grim humor: the 24-year-old cocaine abuser who failed to commit suicide because the razor blade she used to slash her wrists had been blunted by chopping too much cocaine. And there's an unexpected levity in some of the papers' titles: "Love and Haight: The Sensuous Hippy Revisited."

The papers themselves, however, are serious and, in some instances, exhaustive. There is, for example, a review of the effects of more than 70 legal and illegal drugs on sexual functioning — a "valuable reference for both physicians and counsellors who work with substance abusers," says Dr Smith in the introduction.

Also, there is a series of papers on specific drugs — alcohol, cannabis, cocaine, the volatile nitrites, and heroin — and the way they affect sexual functioning.

Not all the findings wil be universally accepted or welcomed:

"The evidence from this study indicates that marijuana, when it affects the sexual experience, affects it in a positive way . . ."

"These cases illustrate that the positive rewards derived from cocaine use — the stimulation and euphoria — overshadow the negative effects . . ."

"The inhalable nitrites may be the nearest thing to a true aphrodisiac . . ."

But there's a danger here of taking some of the findings out of context and stripping away too many qualifications. Also, further research is obviously needed.

For example, butyl nitrite, one of the inhalable nitrites, has recently been linked, by an unproven theory, to a form of cancer that has reached epidemic proportions among some homosexuals who regularly use it in association with sex.

Truly bizarre

Elsewhere in the issue, there is a paper on 102 "sex/drug 'gourmets' from the San Francisco Bay Area." They were questioned to determine current "practices and trends or fads," and to show how much such practices and fads have changed.

Report the authors: Cocaine has slipped in popularity since other studies were made in 1975; meanwhile, the use of volatile nitrites has leapt into prominence; and "disco-hits or minimal doses of MDA and LSD are making real inroads as 'enhancers' and as disinhibitors and fantasy facilitators."

Furthermore, the authors say, "it is of interest that some of the most truly bizarre sexual practices occurred with drugs no stronger than grass or 'rum and coke'." And among sex/drug 'gourmets,' the truly bizarre is truly bizarre: "When I am high — naked, shaven hairless . . . from the neck down, with leather harness on and rings around my (genitals), and my butt-plug in place — I am 100% sexually stimulating to almost all men and women . . ."

Stresses objectivity

Finally, there is a series of papers covering clinical issues, such as the correlation between past incest and sexual trauma, and present drug abuse and sexual dysfunction (the correlation is notably strong), and a series of papers offering specific counselling techniques that could add to the clinical skills of counsellors in both the substance abuse and sexuality fields.

Among other things, they stress that counsellors in both fields must try to develop their skills in an objective and nonjudgemental way. ("Promiscuous" does not describe someone who has more sex than you do, anymore than an "alcoholic" is someone who drinks more than you do.)

Says David Smith: "You have to try, as much as possible, to screen out your own particular ideology and your own particular value judgements."

**Haight-Ashbury Publications, 409 Clayton Street, San Francisco, California 94117*

THE BACK PAGE

Vol. 11 No. 12 2nd Class Mail Reg No. 2776 ALCOHOLISM AND DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO TORONTO December 1, 1982

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Dickens: no reasonable cause

Review committee clears Sobells on scientific misconduct charges

By Karin Maltby

TORONTO — The scientific and personal integrity of two prominent alcohol researchers has been vindicated following a lengthy investigation by an independent review committee.

The husband-and-wife team of Mark and Linda Sobell, PhDs, has been under public attack for several months for allegedly misrepresenting their work on a controlled drinking study a decade ago (**The Journa**l, Aug).

The review committee's "clear and unequivocal" conclusion is that there is "no reasonable cause to doubt the scientific or personal integrity" of the two psychologists.

The committee dismissed most of the allegations against the Sobells in its 123-page report, and generally supported the psychologists on the eight major issues it defined as key in the controversy.

It made no judgment on the validity of controlled drinking as a treatment option.

"The Committee is aware of the differences of opinion within the scientific and lay communities as to whether controlled drinking, as opposed to abstinence, is an appropriate treatment goal for some alcoholics. We have no views and express no opinions upon this matter."

Sobells: detailed documentation

The Sobells, who had declined to discuss the issue publicly since the committee was established, told **The Journal** they believe the Committee's findings have restored their reputation, "and perhaps even strengthened it," said Dr Linda Sobell.

Dr Mark Sobell told **The Journal**: "We're talking about the scientific community — the people who are in a position to evaluate our research. In that regard, I think that our study has been scrutinized much more closely than any study — not just in the alcohol field — but any study I've ever heard of. It has held up to that viewing quite well.

"The amount of documentation is vast, and I don't see how it can possibly hurt us if other scientists know that we have this kind of detailed documentation to support what we published."

SPECIAL:

The complete summary and epilogue of the Committee of Enquiry's Report

Pages 7-10

The Sobells, employed since 1980 at the Addiction Research Foundation of Ontario (ARF) here, plan to continue in their present capacities: Mark Sobell as Head, Socio-Behavioral Treatment Research, and Linda Sobell, as Head, Behavioral Intervention Research.

It was at their request that ARF President Dr Joan Marshman established the review committee in June, following public disclosure that a California group was about to publish data which conflicted with, and minimized the apparent successes of, the Sobells' widely-cited research on Individualized Behavior Therapy.

The research in dispute was conducted in the early 1970s at Patton State Hospital in California when the Sobells were graduate students. It concluded that gamma (physically-dependent) alcoholics who were trained in controlled drinking fared better for the first two years following treatment than alcoholics given traditional, abstinence-oriented therapy.

Since 1973, Mary Pendery, PhD, *et al*, have been attempting to follow-up the Sobells' subjects. On July 9, 1982, the Pendery team published an article in the

(See — Sobells — page 2)

'Important, experimental finding'

Alcohol intake cut in drug trials

By Terri Etherington

TORONTO — Testing of a new drug treatment to reduce alcohol consumption is being seen here as an important discovery in the field of pharmacotherapy of alcoholism.

The drug — zimelidine — effectively reduced alcohol consumption in healthy, non-depressed, heavy-drinking males, says project chief, Claudio Naranjo of the Addiction Research Foundation (ARF).

Zimelidine is used in several European countries in the treatment of depression.

Dr Naranjo, head of clinical pharmacology at the ARF, is excited about the results of the first human study of this application of the drug, and about the possibilities it opens for further research on similar drugs.

The 10-week study, completed in August, showed that zimelidine reduced by 15% to 20% the number of alcoholic drinks consumed, and was also associated with a two- to three-fold increase in the number of abstinent days reported by the 16 male subjects.

Before the study the subjects reported drinking an average of at least four drinks per day or 28 per week.

Basically the drug produces a significant decrease in alcohol consumption, says Dr Naranjo.

He cautions, however, that the findings "don't mean, under any circumstance, that this drug can be used now for treating alcoholics. I would consider this an important finding, a preliminary finding, but basically an experimental finding.

"I am not recommending to anyone to give this drug to alcoholics for this particular purpose.

Naranjo: exciting discovery

"I think there is no evidence to support that indication yet."

Other drugs used in the treatment of alcoholism, such as Antabuse (disulfiram) and Temposil (calcium carbimide) "are predicated on the assumption they will help the subject remain abstinent," the researcher explained.

Zimelidine, on the other hand, has reduction of alcohol consumption as a goal, he said.

While the researchers know the drug works in this way, they don't know why. There are several theories.

"One of the most popular theories is that the drug might be blocking the central nervous system mechanism responsible for the reinforcement afforded by alcohol . . . so that when a person or an animal drinks, he is not getting the positive reinforcement. After a certain time, the behavior will extinguish itself," Dr Naranjo said.

With colleagues Dr Edward Sellers and Dr Martha Sanchez-Craig at the ARF, Dr Naranjo conducted a double-blind, controlled study on 16 male volunteers who had not been treated previously for alcoholism or depression.

In the initial two weeks of the study the subjects did not receive any drug therapy but recorded daily consumption of alcohol. In the second two-week period, the subjects were randomly assigned to receive either zimelidine in a 200-mg per day dose, or a placebo. Subjects then alternated between the drug and placebo in each subsequent two-week period of the study. Medical and psychosocial assessments were made prior to

(See — Drug — page 2)

Birthweight studies may obscure more serious fetal smoke harm

By Alan Massam

LONDON — Smoking in pregnancy may be even more dangerous than clinicians have realized.

This is the conclusion of a unit of the British Spastics Society which conducts research into handicap prevention.

A spokesman for the society said much of the research into smoking in pregnancy had examined the reduction in birthweight which often results. Yet the evidence shows that the majority of excess baby deaths to smoking mothers come from conditions which caused bleeding before birth *(placenta previa* and *abruptio placentae)*.

The spokesman said: "This is of concern in that it suggests that placental changes are occurring which compensate for the smoking-influenced decrease in birthweight, but predispose to other highly dangerous conditions.

"Hence research which only examines birthweight reduction may, in fact, be masking the more serious effects on the unborn child of a smoking mother."

The society concluded that consideration to these observations should be given by any authority proposing to fund research into smoking in pregnancy. It pointed out that incomplete investigations would delay the acquisition of knowledge about the dangers of smoking, and the implementation of measures designed to reduce them.

The report also confirms many of the dangers of smoking in pregnancy observed by earlier workers, including the risks of having a low-birthweight baby, and claims that the benefits of giving up the habit by the fourth month of pregnancy are "enormous."

* *Smoking in Pregnancy — A review*. The Spastics Society, 12, Park Cres, London W1N 4E1.

INSIDE

NEWS

Briefly...

Make mine water

WASHINGTON — Hard economic times don't seem to have stopped wine drinkers in the United States. Table wine imports are up 8% over last year and domestic wine has increased by 4%. However, import of distilled spirits has dropped by 12% and domestic production is off by 9%. People seem to be drowning their sorrows more often with bottled water — 551 million gallons of it last year, more than wine or spirits in gallonage. Sales hit $666 million.

A better chance

TORONTO — Smokers who have suffered myocardial infarction are much more likely to die than non-smoking victims, say three Birmingham, England researchers. The doctors studied 142 patients who suffered their first myocardial infarction before age 45 and followed them up for 10 years. Those who continued to smoke after infarction had "a significantly greater mortality." This confirms findings of earlier studies which suggest "the simple measure of stopping smoking would improve prognosis substantially."

He'll never give up

LONDON — Even after he's dead, John Showers will be speaking out against the perils of smoking. Mr Showers, a Yorkshire publican, has already had his tomb built at the bottom of his pub garden. Now, he's arranging for a tape recorded warning about the dangers of tobacco. It will be activated when anyone visits his grave. Mr Showers has been campaigning against public smoking since 1971 when a friend died from cancer.

Wanton disregard

CALIFORNIA — The California Supreme Court has ruled that an impaired driver can face murder charges if he's involved in a fatal car crash. The court recently reinstated two second-degree murder charges, instead of the usual manslaughter charge, against Robert Lee Watson, saying he "exhibited wantonness and conscious disregard for human life." He was charged in January, 1979, when the car he was driving collided with another, killing a mother and her daughter. His blood alcohol content was 0.23%, more than twice the amount for legal intoxication.

Taking on shebeens

ULSTER — Publicans here are threatening to ignore the law against Sunday opening, claiming they are being driven out of business by the increase in registered clubs. Many of these clubs, say the publicans, are former *shebeens* — illegal drinking haunts — encouraged by the authorities to go legitimate. Pub owners resent the advantage of the clubs; they can stay open Sunday, install gambling machines, pay lower rates, and operate with less stringent fire safety precautions.

DWI in Denmark

COPENHAGEN — In Denmark a conviction for impaired driving brings a very stiff penalty. Danish drunk drivers face a mandatory three-week jail term and loss of licence for a year and a half.

US toughening up on drugs world should know: Turner

By Harvey McConnell

WASHINGTON — The United States has changed its attitude on drugs, and Carlton Turner, chief adviser on drug abuse policy to the White House, wants the world to know.

"Most communications from the US about drugs have been pro-drugs or about how bad American society was, or how decadent, and how things were coming apart at the seams because of our excessive drug use.

"There has been the question of why should (other countries) reduce production of an illicit drug when we appear to have an insatiable desire for more."

Now, he told **The Journal**, the "mood of America" has changed. "And we want to communicate this. We want other countries to know about things like the parents' movement, this grass-roots support.

"We want them to know we have a plethora of unexpected groups supporting the president. We want countries to know we are serious about drug abuse and we are going to do something about it."

He said the US Information Agency will carry the word around the world, and it will not be a whitewash. "We do have our problems and we don't deny them. But, we want to communicate also that we are getting some structure back into our society and trying to deal with them."

Meanwhile, Dr Turner said, some people seem to believe that as chief of drug policy for President Reagan's administration, he should become a "drug czar."

The opposite is true, he said. "My job is making certain policy is implemented.

"Some people think I should get involved in detailed operations. I refuse to do that . . .

"If there are cases where I think the operations might jeopardize our policy I will not hesitate to get involved, and I have done that on a couple of occasions. But the philosophy I bring is working together with a gentleman's agreement on how things are done."

As for a "drug czar" who tells cabinet secretaries what to do, "you have already got that and he is called the president of the United States. President (Ronald) Reagan is very knowledgeable in this field and that makes my job easier."

Turner: mood has changed

'More public understanding, visibility'

Support growing for raising drinking age

By Lynn Payer

NEW YORK — Support is growing in the United States to have all states raise the legal drinking age to 21 years.

"It's almost like a groundswell," said Barry Sweedler, director of the Bureau of Safety Programs for the United States National Transportation Safety Board (NTSB).

The board recently sent a letter to the governors of the 35 states with a drinking age lower than 21 years recommending they raise it.

The letter cited research showing eight of the nine states that raised the drinking age experienced a reduction in nighttime fatal crash involvement among drivers in the affected age group, with the average reduction being 28%.

Mr Sweedler said a number of groups at all levels, from the United States National Safety Council, to a number of state and local groups, had endorsed the proposal.

The US National Council on Alcoholism (NCA) has also adopted a position paper that includes a recommendation to raise the drinking age to 21. (Other recommendations include raising taxes on alcohol, requiring health warning labels on bottles, and restricting advertising.)

Joanne Yurman, director of prevention and education programs for the NCA, says the measure has wide public support.

The relationship between alcohol availability and both teenage alcoholism and traffic accidents now has, she said, "more public understanding and a lot more visibility."

"There's no question at all but that the movement's underway," said Allen Rice, executive director of the Michigan Council on Alcohol Programs.

While only Illinois, Maryland, and Michigan have raised the drinking age to 21 since 1978, five states, Maine, Massachusetts, Nebraska, New Hampshire, and Rhode Island moved it to 20 between 1977 and 1981, and several others, including New York State, recently raised it from 18 to 19.

Sobells ready for US questions

(from page 1)

refereed journal *Science*, citing discrepancies between what the Sobells said they did, and what actually occurred.

Dr Pendery, a psychologist at the Veterans Administration Medical Center, San Diego, limited somewhat her public comments. However, second author, Dr Irving Maltzman, PhD, professor and former chairman of the psychology department, University of California, Los Angeles, told **The Journal** the Sobells' work was fraudulent (**The Journal**, Aug).

Although expected and invited, neither Dr Pendery nor Dr Maltzman met with, or shared any documentation with, the review committee.

The formation of the committee took place when the pending article in *Science* was merely rumor. Committee members were Chairman Bernard Dickens, PhD, LLD, a law professor at the University of Toronto; Anthony Doob, PhD, director, Centre of Criminology, University of Toronto; Harold Warwick, MD, professor emeritus, faculty of medicine, and retired vice-president, Health Sciences, University of Western Ontario; and William Winegard, PhD, former president, University of Guelph (Ont), and past chairman of the Ontario Council on University Affairs.

Both Drs Sobell told **The Journal** they have not conducted controlled drinking work for several years and no longer have very much interest in that research question.

Their views on controlled drinking as a treatment option today?

Dr Mark Sobell: "Controlled drinking, or non-problem drinking I think is today seen as a very viable option for people who are typically called problem drinkers — basically people who haven't become physically dependent on alcohol.

"We were among some of the first people to advocate that it was probably less appropriate for people who have been physically dependent. But, the distinction I want to make is that that's quite different from saying it's not possible with such people.

"The literature shows consistently, and in dozens of studies, that such outcomes do occur. Our assessment, and I think the assessment of most others, is that our best investment of effort is probably in looking at the efficacy of that modality for problem drinkers."

While the ARF-launched investigation is over, the Sobells are prepared to face the possibility of more questions about their work from US groups concerned that public money was used to fund part of their Patton research project (**The Journal**, Oct).

The Sobells have been in correspondence with both the US National Institute on Alcohol Abuse and Alcoholism and the sub-committee on investigations, Committee on Science and Technology, of the US House of Representatives.

Dr Linda Sobell: "Let's just say that we have agreed to cooperate in the ways (the US sub-committee) has requested and leave it at that. We will be verifying our documentation."

Drug opens new alcohol research field

(from page 1)

the study and at the end of every two weeks.

Researchers found that during the administration of zimelidine subjects were drinking less than during either the baseline or placebo periods and were drinking less in terms of both mean daily drinks and number of abstinent days reported.

Although five subjects apparently developed a mild toxic reaction in the liver, Dr Naranjo says the condition is reversible and is thought to be dose-related. Further experimentation with reduced doses will attempt to prevent this complication yet maintain the drug's effectiveness.

Dr Naranjo and his colleagues will continue studies of zimelidine and similar compounds.

"It is our intention to correlate findings in humans and animals to try to identify the mechanism."

Studies at the ARF on the effects of zimelidine on rats also showed a decrease in alcohol consumption. The ARF study replicated an earlier study with rats conducted by Rockman *et al* at Concordia University.

"The reason we are excited about this finding," says Dr Naranjo "is because it is one of the few examples where there is concordance between animal and human data." This opens up possibilities for a whole new field of experimentation on drugs with similar mechanisms of action, he says.

Dr Naranjo hopes, "within a few years we will know if this particular group of drugs really represents a breakthrough in the treatment of alcoholism."

A report of the study will be given at that 1983 annual meeting of the American Society for Clinical Pharmacology and Therapeutics in San Diego, in March.

NEWS

Pressure grows to seize drug traffickers' assets

By Thomas Land

VIENNA — The banking secrets of the global drug syndicates — which often outwit, outrun, and even outgun narcotics law enforcement agencies — may soon be exposed to public scrutiny.

International cooperation among law makers to provide for the investigation of the vast financial transactions of the crime syndicates and the seizure of their assets is now emerging in concrete terms in Italy and the United States after years of debate.

Canada, Britain, and the rest of Western Europe are expected to follow this lead. Meanwhile, the United Nations Commission on Narcotic Drugs has called a conference of the operational heads of the specialist national law enforcement agencies to formulate a joint policy.

The cooperating countries hope to deprive the illicit drug trade of the dual prerequisite of business flexibility — the availability of highly liquid assets backed by sophisticated banking services.

The Vienna-based International Narcotics Control Board declared three years ago: "Illicit (drug) production and trafficking have grown to vast proportions, and the attendant financial transactions have generated sums of such staggering size that the economic and political stability of some countries is now threatened.

"These funds support an ever-growing trade," the Board said. "Governments should take stricter domestic and international measures to investigate the movement of this ill-begotten capital. Such action will make it possible to identify and eliminate the financiers of organized crime."

Italy has now enacted legislation giving judicial authorities unprecedented powers in crime investigation, including access to bank accounts suspected of harboring Mafia funds. And in the United States, President Ronald Reagan's administration has declared its intention to use its considerable powers provided under existing legislation to uncover the banking secrets of drug runners and to share them with law enforcement agencies of other countries.

These developments follow a little-publicized meeting in England in 1982, attended by senior police officials from North America and Western Europe, as well as Interpol. Frustrated by the effective financial immunity of the drug syndicates, they agreed to press their governments into action.

Widespread interest in the banking secrets of the drug trade was generated by a I98I trial in Britain which resulted in long prison sentences but left the assets of the offenders intact.

The Italian legislation was passed in haste, following the murder of General Carlo Alberto dalla Chiesta, a special commissioner appointed to curb the power of the Sicilian Mafia. Several prominent Italian bankers have recently met with violent death. The Sicilian Mafia is believed to have earned half a billion dollars annually in profits since 1976, largely through the heroin trade in North America and Western Europe.

Concerned by several recent attempts by criminals involved in the $80-billion-a-year North American drug trade to gain control over local banks, Washington has given "high priority" to the investigation of financial dealings by "key traffickers." It intends to make full use of domestic laws and international records, testimony of witnesses, and information in administrative and judicial documents.

These steps, however, confront the controversial principle of banking secrecy which is vigorously defended by some countries. Banking legislation in secretive Switzerland already provides for the exposure of accounts in connection with investigations into serious crime such as drug running; but in the Caymans, banks are forbidden even to confirm the existence of an account except at the instruction of customers.

Nevertheless, the banks and the law enforcement agencies of the cooperating countries can do a great deal to intercept illicit funds before they reach such havens.

Recommendations soon

Canada debating drug money

By Mark Kearney

TORONTO — Legislation that would allow authorities to seize the financial assets of drug criminals could be introduced in Canada by next autumn.

A federal-provincial task force is now examining ways for the law to deal with profits of crime, and recommendations could be ready soon, says Rick Mosley, coordinator of the task force and a legal counsel with the justice department in Ottawa.

The legislation will try to ensure that crime does not pay, he told **The Journal.**

Mr Mosely says the recommendations will be presented to justice authorities across Canada and, if they are accepted, legislative proposals could be ready by autumn.

For now, Canada's Criminal Code makes possession of property obtained by crime illegal. But, it does not provide for forfeiture of profits associated with the crime.

Thus, a person who has made money selling drugs may be imprisoned but have his assets waiting for him on release.

The task force was established partly in response to a report prepared by the attorney-general's office in British Columbia entitled *The Business of Crime*.

Endorsed by the Canadian Association of the Chiefs of Police last year, the report evaluates the United States' Racketeer Influenced and Corrupt Organizations (RICO) Statute from a Canadian perspective, and recommends a similar law here.

The RICO Statute provides for the forfeiture of profits of any crime for which there was a conviction, or of any interest in an enterprise that was acquired or maintained in violation of the Statute. It also makes provision for preventing accused people from disposing of assets prior to trial.

While the BC report notes such a law in Canada could lead to long and costly investigations, and raise concerns about violations of rights, Mr Mosley says it's difficult to determine how much it would cost because it hasn't been done here before. As for civil rights, he says, there was "little public outcry" following enactment of the RICO Statute in the US.

Another concern, however, is the question of disposition of assets, such as a business or property, that are financed partly illegally and partly legally, says Mr Mosely. Should all or part of them be seized?

"American prosecutors," the report notes, "have experienced difficulty in tracing the flow of funds from illegal activity through the laundering process to its investment in a legitimate enterprise."

Thus, the Canadians are recommending a reverse onus provision. This would assume that any assets acquired during the time of criminal activity were acquired with illegal profits, and the burden of rebuttal should be shifted to the accused.

Such legislation would make cooperation among various international law enforcement agencies essential, says Mr Mosley. Criminals in Canada, for example, may place their assets outside the country as a way of protecting them from any RICO-like law.

Superintendent Rod Stamler of the drug enforcement branch of the Royal Canadian Mounted Police (RCMP), who is also a member of the task force, says he hopes international cooperation will be easily achieved because many countries are looking at establishing similar laws.

"Unless you attack the profit aspect of it, you really can't get at the organized crime," he told **The Journal**. "In the drug field we (police forces here and in other countries) are all committed to stamping it out.

"I'm very much in favor of a type of law or laws, within reason, that remove the profits of crime."

In the meantime, the RCMP has established the Anti-Drug Profiteering Program which is designed to trace and seize, if possible, assets related to drug crimes (**The Journal**, March).

The special units, in major cities across Canada, have so far managed to seize hundreds of thousands of dollars in cash and assets directly related to drug sales, Supt Stamler says. However, while the program looks promising, legislation is still needed to deal with forfeiture of profits, he adds.

Flourishing grape harvest pains champagne makers

PARIS — Pouring their bubbly down the drain may be one option facing champagne producers here as they gather the best harvest of the century.

In most agriculture industries, a bumper crop would be a signal for rejoicing, but strict regulations passed in I974, aimed at preserving quality and keeping prices high, allow only I3,000 kilos (just under five tons) per hectare to be turned into champagne.

After three years of bad weather, the producers welcome the good harvest but are faced with a dilemma. Either abide by the rules and see their surplus turned into vinegar or industrial alcohol, or cheat and run the risk of being put out of business by the Comité Interprofessionel du Champagne.

There are 15,000 small producers, each with one or two hectares, who make up the bulk of the champagne industry. One of them suggests he may declare I3,000 kilos, press the rest, and leave it to ferment and mature for three years in a secret cellar.

Free enterprise triumphs, US self-sufficient

By Wayne Howell

"We've done it," cried the presidential aide as he rushed into the Oval Office.

"Done what?" asked the president. With a quick reflex action he pulled back his hand. Dammit, he had been told not to play with the buttons. Could he have pushed the one marked 'A' by mistake? That would mean he had either called up Air Force One, or, or — there was something nagging him at the back of his mind. Ah yes, Armageddon. He hunched sheepishly in his chair.

"Do you think they'll have the capacity to retaliate?" he asked nervously.

"No way Mr President. American science has produced a product of devastating potency."

"Thank God for that. Now we're going to have to draft up some sort of statement about this. It's going to be tricky. No matter what we say, nervous Nellies like the Pope are not going to like it. But all we can do is express our sincere regret about the incident and pledge that the inadvertent destruction of the Soviet Union will in no way affect our relations with . . ."

"Mr President — when I was talking about the capacity to retaliate, I was referring to the Third World countries that are the major producers. What on earth are you talking about?"

The president confessed he had been toying with the buttons and he might have pushed the Armageddon button by mistake.

"Not to worry Mr President. It takes two button-pushes to destroy the Soviet Union, three to destroy the world — it's what we call a fail-safe system."

The president relaxed for the first time.

"I guess I just panicked for a moment. Sorry. Now go on. What were you saying we had done?"

"We've achieved self-sufficiency Mr President . . ."

"I knew we could do it," said the president, leaping up from behind his desk. "The doom-and-gloomers said we would be relying on imports well into the next century. But I had faith in America. Faith in the American free-enterprising spirit. Faith in the entrepreneurial skills of individual Americans. Faith that America's men of science would rise to the challenge. Faith that we as a people would find and develop domestic sources and produce the reserves we need to sustain the American way of life. American dollars are not going to flow out to the Third World anymore, playing havoc with our balance of payments and draining the wealth of this great nation."

"Right on, Mr President. We can tell those Middle Eastern and South American profiteers that we won't be held up to ransom anymore. Good old American know-how and science and technology have won the day; not only do we now have the quantity, we also now have the quality."

"That takes a load off my mind," said the president, "because you know what it's like with all these environmentalist freaks around, always complaining about sulphur and whatnot . . ."

"Sulphur?"

"Yes, sulphur. Isn't that the problem with the low-quality stuff? Sulphur being discharged into the atmosphere during the refining process? It makes that acid rain that gets the Canadians so upset."

"Mr President, what on earth are you talking about? I'm not talking about self-sufficiency in energy production. I'm talking about our third most valuable cash crop; I'm talking about agricultural production. Thanks to the American free-enterprising spirit, American entrepreneurial genius, and the innovations of American biological science, we have achieved it: self-sufficiency in marijuana."

"This," said the president, as he dismissed the aide, "is not shaping up to be one of my better days."

NEWS

RESEARCH UPDATE

Smokers get to menopause sooner

A study of 5,645 Danish women suggests menopause comes sooner to smokers. The investigators, from the University of Copenhagen, compared the proportions of post-menopausal women among smokers and non-smokers aged 44 through 53 years. For women aged 44 through 46, and for those 52 or more, the proportion of post-menopausal women was similar among smokers and non-smokers. From 47 through 51, however, there were significantly more post-menopausal women among the smokers. For example, among those who were 48 years old, 28% of the smokers were post-menopausal compared to only 17% of the non-smokers. Similarly, at age 50, the proportions were 51% vs 34%. The researchers examined the possibility that the smoking women's greater leanness might be responsible for the difference. However, when smokers and non-smokers of the same bodyweight (and same age) were compared, the smokers were still more likely to be post-menopausal.

Acta Medica Scandinavica, 1982, v.212:137-139.

THC against tremor

Tetrahydrocannabinol (delta-9-THC), a major active ingredient of marijuana, could help to control the tremors and ataxia (muscular discoordination) that frequently afflict multiple sclerosis (MS) sufferers. In a placebo-controlled, single-blind experiment, David Clifford of the Washington University School of Medicine, St Louis, gave delta-9-THC orally to eight MS patients and found that two responded with a sharp reduction of tremor. One of the patients, with severe ataxia of the hands, managed to write legibly for the first time in four years after receiving a 15-mg dose of THC. Five of the other six patients had some subjective improvement on THC. Dr Clifford says that THC's psychoactive properties make it unsuitable for general use against tremor but he believes that either natural or synthetic analogues may be useful.

Journal of the American Medical Association, Nov 12, 1982, v.248:2215

Opiate deaths dropped in late 1970s

Between 1975 and 1979 there was a precipitate drop in the number of United States deaths coded as due to poisoning by "opiates" or "intravenous narcotism," indicates a study of drugs and medication poisonings in the 1970s. Deaths ascribed to poisoning by opiates accounted for 38% of all unintentional drug poisoning deaths in 1975 but only 15% of these deaths in 1978, with the absolute number of such opiate- and narcotism-related deaths dropping to 292 in 1978 from 1,184 in 1975, a 77% decrease. All race-sex combinations showed the drop, though the most dramatic declines occurred among non-white males aged 20 to 29, dropping to under 10 per million per year in 1978, from more than 50 per million per year in 1975, almost identical to the figure for white males in the same age group. Researchers Judith S. Samkoff of the Medical College of Pennsylvania and Susan P. Baker of Johns Hopkins School of Hygiene and Public Health suggest that the drop in deaths related to opiate poisoning or heroin dependence coincides closely with the opium poppy eradication program started in Mexico in 1976 having a major impact. They also speculate that the increasing supply of Southwest Asian heroin after 1979 may produce a new upswing in opiate-related deaths.

American Journal of Public Health, 1982, v.72:1251-1256.

Running addiction — it's not the endorphins

If there is something "addictive" about long-distance running, the effect is probably not based on endorphins, the body's own opiate-resembling substances. In a study conducted at the University of Hawaii, the mood of 11 runners was measured by a 65-item scale before and after a one-hour run. Then to see if endorphins were in any way involved in the significant improvement of mood shown by most runners at the end of their run, the researchers gave each injections of naloxone. Naloxone, an opiate antagonist, has previously been shown to banish endorphin effects. Naloxone given the runners, however, had no effect on mood. "The failure of naloxone to reverse the running-associated mood shift indicates that endorphins are not involved," investigators Richard Markoff, Paul Ryan, and Ted Young conclude.

Medicine and Science in Sports and Exercise, 1982, v.14:11-15.

'Flu bug bites smokers hard

During an influenza epidemic, male smokers are much more likely to get bitten by the 'flu bug than are non-smokers and, once bitten, are more likely to develop a severe case of 'flu. This is the message from a study of 331 healthy young men living on a closed Israeli military base. Smokers and non-smokers on the base were divided nearly evenly — 51% vs 49%. When the bug hit the base, 68.5% of the smokers got sick, compared to 47.2% of the non-smokers, a highly significant difference. Moreover, the more a soldier smoked, the better his chances of developing a severe case of 'flu. While only 30% of non-smokers were severely affected, 43% of light smokers (up to 10 cigarettes per day), 52% of moderate smokers (up to 20 per day), and 54% of heavy smokers were hit hard. The researchers add that passive smoking on the part of the non-smokers probably elevated the incidence of 'flu among them; otherwise, the disparity between smokers and non-smokers probably would have been even greater. Given this clear link between smoking and 'flu susceptibility, the researchers believe that, health considerations aside, "economic considerations alone should stimulate anti-smoking intervention policies in large industrial and service organizations."

New England Journal of Medicine, Oct 21, 1982, v.307: 1042-1046.

Austin Rand

People fear distant hazards ignore risks in drink, drugs

By Betty Lou Lee

TORONTO — People demand a high degree of protection from nuclear power plants, commercial airlines, and medications.

But when they have it in their power to control potential hazards by, for instance, quitting smoking or drinking, or wearing protective equipment at work, they don't do it, says Stuart Smith, chairman of the Science Council of Canada.

"Risk-avoidance behavior is almost totally devoid of rational thought," Dr Smith told the opening session of a two-day symposium on risk sponsored by the Science Council and The Royal Society of Canada.

People also over-estimate risk when it is up to others to protect them, Dr Smith noted. They worry about being injured in a street crime, and demand a high level of police protection, when such risks in Canadian cities are "negligible" compared to the risk of injury in an automobile accident.

"It is not rational to put ourselves at risk, but we do," he said. Some, like Mount Everest climbers, seek it out and feel exhilaration at overcoming risk.

As a psychiatrist, Dr Smith dealt with people who abused drugs and attempted suicide, with a willingness to gamble their lives in a "trial by ordeal" that could bring "a heightened feeling of well-being and importance."

Risks have more impact on the public if there is a direct cause and effect with a short time gap, and if the effect is visible, he said.

"We demand that the food and drug directorate protect us from ingested substances, and we have an enormous bureaucratic mechanism to do so. But we don't demand the same protection from inhaled substances, and there are new ones in the workplace every year.

"Why we guard our esophagus and not our windpipe, I don't know."

In multi-factorial situations, the public always focuses on the simplest factor, Dr Smith said.

Road and automobile design, poor driver education, policing, and drinking may all contribute to a traffic accident, but the public focus is on drinking drivers.

Even unnecessary risks are accepted in order to accomplish a task, Dr Smith said. Some municipalities will accept industrial pollution if they fear a clean-up will jeopardize jobs, but it can often be accomplished without job loss.

"People would sooner be able to earn a living than eliminate some long-term, vague risk to health."

They will also accept x-ray exposure higher than necessary because they associate it with medicine, even though it presents a "far greater hazard than all the nuclear plants."

Nevertheless, he said, there is no justification for keeping people ignorant of a hazard simply because they will react irrationally.

Smith: trial by ordeal

Cash bind forces women's centre to modify addictions programs

By Rhonda Birenbaum

OTTAWA — Amethyst, Canada's first women-only addiction treatment centre, is having to turn to the private sector for funding and, in doing so, is also changing policy and programs.

A 1981 funding squeeze pushed the centre's image into the background as organizers scrambled for money to keep it running.

A recent Ontario ministry of health injection of $40,000 to cover the 1982-83 budget will be the last public sector money coming to the centre, says Sharon D'Arcy, Amethyst education coordinator.

"We're moving out of the public sector, away from having the government take care of us," said Ms D'Arcy. "The good times are over."

Amethyst has also begun charging for services, although staff say no woman will be turned away because of an inability to pay.

D'Arcy good times over

Ms D'Arcy has been appointed public relations officer to implement a program to attract attention, and money, to the centre.

In addition to traditional fund-raising activities, such as fashion shows and garage sales, Amethyst has established a speaker's bureau, with staff members available to speak about women and addiction.

Once for women only, the centre is now also open for co-ed meetings of Alcoholics Anonymous (AA) once a week.

"The mixed AA meeting is a public statement that the emphasis here is on treatment, rather than on the exclusion of men," Ms D'Arcy told **The Journal**.

However, the main thrust of the program continues to be treatment of addictions in women. While there are no men on staff, up to one-third of the positions on the board of directors may go to men. The centre does provide support services for male relatives and friends of the women in treatment.

The program itself was also re-evaluated and has been changed to accommodate working women. It now includes five days of intensive workshops followed by evening sessions spread over eight weeks, rather than the three weeks of full days previously required.

The first group of women began this new program in November.

Sessions include nutrition information, relaxation therapy, and specific information on what alcohol and drugs can do to the female body.

The success of the Amethyst program is reflected in the 45% of women who are abstinent up to a year following completion of treatment.

These figures give Ms D'Arcy and her colleagues the confidence to continue rallying for the Amethyst cause.

But she scorns the lack of government interest: "They're collecting millions of dollars in taxes from alcohol sales. You'd think some of that could come back into services in the community to treat alcoholics."

Winnipeg prepares to quit

WINNIPEG — A pilot program here to help people stop smoking could spread to other Canadian communities next year.

Jeanette Bartlett, acting program consultant with Health and Welfare Canada, sponsor of the program, says the results of the November campaign will be evaluated over the next six months to determine changes in participants' smoking habits.

The program, Time to Quit, includes self-help booklets which provide smokers with tips on how to become non-smokers, a television series of three, 30-minute shows, and a community guide to organizing a non-smoking project.

NEWS AND COMMENT

Disinfectant misuse sparks legal control debate

By Eleanor LeBourdais

VANCOUVER — A common household disinfectant is becoming the drink of choice among increasing numbers of this city's skid row alcoholics.

Lysol spray disinfectant has been gaining in popularity because it is accessible, cheap, and contains 67% anhydrous ethyl alcohol. Information on the container suggests the alcohol has been "denatured" to make it unfit for human consumption. However, users are drinking the disinfectant anyway, mixed with wine or water.

Community workers affiliated with the Vancouver Downtown Eastside Residents Association (DERA) recently collected from favored drinking spots some 800 empty Lysol cans in only 10 hours. Surveys of local merchants, conducted by east side police and the DERA, found 10 local stores offering Lysol spray for sale, along with 14 others carrying Chinese cooking wine, another high-alcohol product sold outside liquor stores.

Without being requested to do so, two large east side department stores have already decided to remove Lysol from their shelves. Frank Robertson, executive vice-president of Woodward's, ordered stock pulled from the Hastings Street store after learning the east side outlet had a higher sales volume of Lysol spray than other Woodward's stores. Army and Navy, located near Woodward's, also elected to remove the product from open display.

In a special report by DERA's street safety committee to the mayor's task force on drug and alcohol abuse, the association has asked Vancouver's city council to press for amendments to the Liquor Control Act to make consumption of substances containing denatured alcohol, or sale of such substances for the purpose of consumption, illegal, as in Saskatchewan.

However, Vancouver police inspector Noel Larkin believes it would be difficult to enact such legislation to stop sales of Lysol to alcoholics, as it would interfere with the rights of customers who use such disinfectant agents for legitimate purposes.

"I'm recommending that we try to get cooperation from merchants, with a view to reducing sales to people who are obviously alcoholic," he said.

While no deaths have yet been attributed directly to the consumption of Lysol, public health officials are worried. The denaturing process supposedly rendering Lysol unfit for human consumption, includes .1% phenylphenol, which is highly toxic in strong concentrations. Heavy concentrations can burn the throat and stomach lining, induce nausea, vomiting, and diarrhea, reduce blood pressure, cause convulsions or coma, and lead to cardiac and respiratory complications.

While consumption of Lysol for intoxication purposes appears to be a relatively new fad on Vancouver's east side, there is evidence some alcoholics have been drinking it for as long as four years.

GILBERT

'. . . journalists and scientists have a lot more in common than most scientists realize.'

Science and journalism

By Richard Gilbert

As a scientist, I share scientists' caution about dealings with the media. As a politician, I subscribe to the aphorism that it mostly doesn't matter what the media write or say about you as long as they spell your name right. As an occasional journalist, working for this newspaper, I have been dismayed by both the inscrutability of scientists and the insouciance of politicians. Clearly my thinking about science and journalism is muddled. This column, suggested by the editor, is a form of self-therapy.

The scientists' caution and the politicians' courting are both responses to the power and influence of the media. This power is no new phenomenon. Public awareness of it dates at least as far back as the early 19th century, when the notion of the fourth estate of the realm was developed.

Fourth Estate

The fourth estate, according to Eric Patridge's valuable Dictionary of Clichés, is a cliché, but not one that is "particularly hackneyed, or objectionable." The phrase was popularized by Thomas Carlyle, a Scots writer-philosopher who referred in 1839 to the three estates of parliament (nobility, bishops, and commons) and a fourth estate, sitting in the reporters' gallery, "far more important than them all."

The cliché survives, in spite of its obscurity and pomposity, because it has some meaning. The press is powerful; newer forms of expression, particularly television, have broadened the power. To a large extent science is responsible. Science makes journalism possible and increasingly effective by remarkable advances, mostly electronic, in the organization and transmission of information.

The July issue of *Microcomputing* magazine featured an account by freelance reporter David Kline of how he wrote and transmitted reports on the guerrilla war in Afghanistan using his portable Osborne 1 microcomputer (the same kind as this column is being written on). Kline was able to compose properly edited copy within sound of gunfire, store it for an hour or two while he found a phone, and then relay it directly by phone line to the printing presses of the *Chicago Sun-Times* for inclusion in that day's edition. The *Microcomputing* article was embellished with photographs of guerrilla fighters standing proudly around Kline's Osborne, apparently pleased that news of their exploits was being conveyed with such dispatch.

Science reporting, even in popular newspapers, is becoming remarkably sophisticated. The point is illustrated by a scan of the "Trends and Ideas" page of the November 7 issue of the *Toronto Star*, the best-selling newspaper in this region. Six articles were featured on this ad-free page. Five were about aspects of scientific progress. Only one was whimsical — about how perambulating robots of the kind deployed in trade shows to interact with visitors and hand out business cards sometimes just "walk away," never to be seen again.

One of the other four articles on scientific matters on this *Toronto Star* page was a brief item on fears being expressed by the USSR public about their government's proposals for a large increase in the number of nuclear power plants. The other three were longer articles on, respectively, the ethics of genetic engineering, the work of the mathematical physicist Stephen Hawking, and muscle transplants in human patients.

Sophistication

Two of the three articles presented sophisticated concepts. On genetic engineering — "If we begin to intervene, are we likely to disturb the balances that keep our world self-sustaining? Are we going to have to become continuously involved to keep the world a habitable place?" On Hawking's notion that there may be an end to time — ". . . the progression [of time] depends on the presence of a critical amount of material in the universe, and the known quantity of cosmic dust and other substances falls short." The article on muscle transplants, by *Star* reporter Marilyn Dunlop, described microsurgery techniques used at the Toronto General Hospital, "the foremost muscle-transplant centre on the continent."

Journalists are embracing scientific progress with some enthusiasm, both as a means of making their work more effective, and as something to report on. They recognize an enormous demand for informative and understandable articles about scientific progress and its implications.

Scientists, by contrast, are mostly standoffish in their regard for the media. This is in spite of the fact that, to some extent, journalism makes science possible in our society. It does this by glamorizing, or at least making available to a wide range of people, what is most often a very dull and unprofitable activity, and thereby helping to ensure continued funding.

Standoffishness

The standoffishness of scientists was fully discussed in a recent article by Robert McCall and Holly Stocking in *American Psychologist*, the monthly house organ of the American Psychological Association. Its title was, "Between scientists and the public: Communicating psychological research through the mass media." The article was written for and mostly about psychologists, but most of it applies more generally to all scientists.

McCall and Stocking gave three main reasons why some psychologists are antagonistic toward journalists and avoid interacting with the popular press. Some, they wrote, may not think of the press as a vehicle for implementing social policy, and may think instead that legislative change may be the only efficient means. The authors pointed to instances where information provided in the media had reduced coronary risk factors in one medium-sized town, and had caused 1% of the population of one medium-sized country to quit smoking — at a cost of one dollar a cure.

The second reason given for the shyness was that scientists hesitate to tell half a story while they are busy working on the other half. McGill and Stocking responded that "people make decisions daily, with or without our information, and they could use the best information available at the time, even if it is incomplete."

Errors

Most of the scientists' antagonism is to do with the third reason: "cooperating with the media is fraught with peril — journalists over-simplify research, sensationalize it, or just plain get it wrong." Accuracy is the real bugaboo, but McCall and Stocking made some interesting observations. One was that scientists themselves make many errors — especially when they are being interviewed for the media — or fail to find many errors when they are given an opportunity to review drafts of journalists' reports. Another was that major magazines employ "fact checkers who document all factual statements and quotes in every article they publish — and there can be up to 300 facts in a 2,000-word story . . . . . no technical publication is scrutinized to this extent."

McCall and Stocking stressed the point that journalists and scientists have a lot more in common than most scientists realize. Both groups, for example, have been found to rank the importance of the following in an identical manner: accuracy, interest to readers, usefulness to readers, prompt publication, and uniqueness. Two studies have found that reporters' rankings of the news value of scientific topics are more similar to scientists' rankings than they are to scientists' estimates of how they think reporters would rank the same topics.

There are differences, too. One is that "journalists don't use books — they use the telephone," as psychologist James Hassett found when he left Boston University for a year to work for the magazine *Psychology Today*. McCall and Stocking noted that "although this approach [phoning contacts for quotes] often results in the same scientists being cited in articles on many different topics, the system can identify in a very short period of time a set of leaders in a field who represent a balanced collection of viewpoints." Mention was also made of the differences in format between scientific and journalistic reports. The chronological sequence of the scientist's report — prediction, method, results, conclusions, and implications — is usually reversed by the journalist, who puts conclusions and implications first to provide "vivid headlines and grabby leads" that can "sell" information to the public.

McCall and Stocking concluded that "The public needs psychologists' research information, and they in turn need the public's understanding and support. The media and scientists underrate each other as potential partners in the communication of psychological research findings."

Improvement

But things are better than they used to be. Veteran medical reporter Joan Hollobon, who writes for the Toronto *Globe & Mail*, told me that even a few years ago researchers and clinicians would usually not allow her to use their names "to avoid the snide cracks from colleagues."

"Now," she added, "there is much greater willingness to talk and be publicized, because research money is tight — and publicity seems to lead to funding — because scientists and physicians seem concerned about their deteriorating public image, and because they are touched by the greater openness of our society."

Thomas Carlyle advised that nothing is more terrible than activity without insight. His aphorism would be an apt description of this article, which must be considered a failure as therapy because it has generated none of the sorely needed insights into how science and the media interact. But writing it has set me thinking about this rich subject, and I hope to return to it in a later column.

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Ignorance, stereotyped thinking crippling employee aid plans

I read with interest but also with real disappointment your article regarding Employee Assistance Programs (EAPs) and drug use (**The Journal**, Oct).

As a 10-year veteran of occupational programs, I was astounded at the incredible ignorance reported regarding basic EAP tenets. First, supervisors and company personnel should never be in a position of diagnosing, or even caring about, the nature of a specific problem; they need only be concerned about the quality of the work performed by the employee. That a supervisor would know the nature of an employee's problem is actually irrelevant to his/her function in an EAP.

Second, EAPs by definition are aimed at dealing with all problems, not just alcohol problems. A discussion of specific work performance indices for alcohol problems, other drug problems, schizophrenia, hypoglycemia, or agoraphobia has no place in a discussion about EAPs because *any* performance problem is reason for referral to a professional diagnostic component, whose task it is to determine the nature of the employee's difficulties.

Third, the day of the pure alcohol or pure other-drug user is long past. It is better to expect that if there is one drug, then probably there are others, whether prescribed or not. Such stereotyped, either-or thinking on the part of providers or EAP managers leads to much misdiagnosis and, ultimately, mistreatment. Once again, if job performance is maintained as the criterion for referral, then isolating differential symptoms or generating individual profiles becomes moot.

The failure of EAPs over the past 10 years can be traced directly to our difficulty in implementing the original "broad brush" philosophy. Instead, we have often said one thing, namely, "we are interested in helping any troubled employee," and done another, "send us your alcohol troubled people." When we place supervisors in diagnostic positions, we handicap the program's ability to engage in early diagnosis and intervention, especially of alcohol problems, because the supervisor and employee alike will usually only identify stereotyped, chronic, and severe alcohol problems. Truly successful EAPs ask only that troubled people, not specific troubles, be identified.

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EAPs can help
Workers on drugs

Harvey McConnell's article on the discussion of Employee Assistance Programs (EAPs) at the ADPA (Alcohol and Drug Problems Association of North America) was interesting (**The Journal**, Oct). The panelists referred to either have limited expertise in implementing EAPs in a profit-motivated environment, or Mr McConnell's reporting of their comments is shallow.

Drug treatment and prevention efforts can be implemented within the broad range of services offered within the scope of an EAP. We have had the opportunity to do just that in nine corporations over the past six years.

There are limitations which must be outlined, guidelines which can be implemented, and we must keep in mind the corporations are in the business of making profit. Profit is a worthy goal. If a corporation can improve profit, as well as assist the employees, then two worthy goals have been achieved.

It is unreasonable to expect the program to rid a company of all suspected drug users. If that is the goal, the EAP will be of little value. A company can minimize the chances of a drug user being employed by reviewing the pre-employment screening process.

A policy statement should be issued for all applicants to read at the time they are applying for a position. If an applicant is seriously considered for a post, bodily fluid analysis can be undertaken at the time of the occupational health physical. As long as the procedure is implemented in a universal fashion within the screening process, and all applicants are informed of the requirement for employment, it is legal.

The EAP should be in place to assist employees who seek aid and to counsel employees who are discovered to have problems, whether they be related to drug use or not. The EAP and its inclusive guidelines are not to be fuel for a witch hunt.

When an employee is being considered for referral to a treatment facility, it is vitally important for the EAP counsellor to be familiar with that service provider. The fact a treatment facility has a government grant or a name which implies expertise in the treatment field should not automatically qualify the agency for corporate referrals. The eventual success or failure of the treatment effort is directly proportional to the appropriateness of the treatment referral.

Corporate EAP efforts can be expanded by those of us in the business of providing expertise to industry. We should assist corporations in their profit motive and not attempt to change them into social service agencies.

Robert F. Hickey
President
Employee Assistance Associates
Kansas City, MO

'Excellent source'

I find **The Journal** to be an excellent source of up-to-date information on the broad area of addictions. I work with prospective teachers, and information geared to the school-age population is most appreciated

D. Wallace
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***The Journal* welcomes Letters to the Editor. Letters may be sent to the Editor, *The Journal*, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.**

SPECIAL SECTION

The Journal

Excerpts from the

REPORT of the Committee of Enquiry into Allegations Concerning Mark and Linda Sobell

One of the most dramatic and controversial issues to surface in recent times in the addictions field, and, indeed, in the scientific community in general, has been the serious allegations of scientific misconduct against Drs Mark and Linda Sobell (See story page 1, and The Journal Aug and Oct).

After a painstaking and lengthy review, an independent Committee of Enquiry has reached the "clear and unequivocal conclusion" that there is "no reasonable cause to doubt the scientific or personal integrity" of the psychologists employed at the Addiction Research Foundation of Ontario (ARF) since 1980.

Although the finding is clearly important to both the Sobells and to the ARF, in the words of ARF President Dr Joan Marshman: "The report's significance extends beyond the issue of the integrity of two scientists; it also speaks to the conduct of research, the process of criticism in the scientific community, and the importance of careful reading of the treatment research literature as a prerequisite to its responsible discussion and application. I therefore view the report as an important contribution to the scientific community and to the alcohol field."

As a service to its readers, The Journal presents here, in their entirety, both the summary and the epilogue of the 123-page report.*

SUMMARY

The summary which follows outlines the issues to which the Committee addressed itself, its overall conclusions, and the *major* evidence that led the Committee to each conclusion. The summary is, by its very nature, incomplete, and the reader should be cautioned that the Committee's conclusion in each instance is based on much more information than can be summarized here. The interested reader is, therefore, urged to refer to the relevant sections of the full report for our more-complete analysis of each issue.

In 1970, Drs Mark and Linda Sobell designed a study to evaluate the effect of different forms of treatment for *gamma* alcoholism, using a group of alcoholics from Patton State Hospital in San Diego, Ca. Within each treatment goal, they assigned subjects randomly to an experimental and a control group, and used daily drinking disposition as their main measure of treatment outcome. In 1972, they published a Monograph reporting their results, and in 1973 they published results of the first-year, follow-up study. The second-year, follow-up study on these patients, published in 1976, showed that a group receiving individualized behavior therapy with the goal of controlled drinking functioned significantly better than a control group receiving conventional state hospital treatment oriented to abstinence.

An independent, third-year follow-up of the same groups by Caddy *et al* published in 1978, also reported significantly better results in the controlled drinking group as measured by drinking and other life-functioning measures.

During this course of events, Dr Mary Pendery and Professor Irving Maltzman obtained the names of subjects in the study and subsequently reported, with Professor L.J. (Louis Jolyon) West, their own review of these patients in an article entitled *Controlled Drinking by Alcoholics? New Findings and a Reevaluation of a Major Affirmative Study.* (*Science*, July 9, 1982.) Prior to this a Draft of this Article entitled *Controlled Drinking by Alcoholics? Refutation of a Major Affirmative Study* received considerable circulation. (These are called the Article and Draft respectively.)

In 1980, the Sobells moved from the United States to Canada where they are now employed by the Ontario Addiction Research Foundation (ARF).

Allegations, both implicit and explicit, concerning the Sobells' scientific and personal integrity have been made as a result of the Pendery *et al* papers, and in June 1982 the ARF appointed an independent Committee of Enquiry to review the problem and to determine whether there is reasonable cause to doubt the scientific or personal integrity of Drs Mark and/or Linda Sobell.

The Committee is aware of the differences of opinion within the scientific and lay communities as to whether controlled drinking, as opposed to abstinence, is an appropriate treatment goal for some alcoholics. We have no views and express no opinions upon this matter.

To determine whether the Sobells had or had not maintained scientific and/or personal integrity in the conduct and presentation of their studies, the Committee identified eight (A-H) major issues and reviewed available evidence.

ISSUE A

Did the Sobells' published results include accurate rehospitalization data for the Controlled Drinking Experimental (CDE) subjects, particularly in the first year follow-up?

Implied is the allegation that the Sobells' data as presented in their published Monograph (1972), and paper (1973), and elsewhere, are not consistent with the presentation by Pendery *et al* (1982).

Findings

The Committee finds the Sobells' published data to be accurate, and concludes unequivocally, that there is no evidence of fraud, deception, dishonesty, or unethical behavior, so far as the Sobells are concerned.

Evidence

Although the *Science* Article is subtitled *New findings . . .*, the most important finding related to this issue is that Pendery *et al* have presented no new findings. In one of their 1973 papers *(Behaviour Research and Therapy)*, the Sobells report that the controlled drinking group spent, on the average, 11.34% of their first year after treatment in the hospital (alcohol related). The Committee examined records of the hospitalizations which constituted this 11.34% and discovered that each of the hospitalizations referred to by Pendery *et al* (Table 2) is included in the original published report by the Sobells. Indeed, the Sobells' summary statistic on this group (p608) includes hospitalizations not reported by Pendery *et al*. Hence on this issue, it is clear that the Sobells' published reports include *more* hospitalizations for the CDE group than did the Pendery *et al* report. The implication that the Sobells were not aware of or chose not to report the accurate hospitalization data for the CDE subjects is clearly false.

ISSUE B

Were the outcomes for the CDE subjects honestly presented as such in published articles, in view of the subsequent incidence among them of alcohol-related deaths?

Implied is the allegation that the Sobells improperly presented subjects as having been successfully treated to become controlled drinkers when they went on to have a high incidence of alcohol-related deaths. It is also implied that the reported incidence of death was abnormally high for the CDE group.

Findings

The Committee finds no reasons upon which to doubt the Sobells' scientific or personal integrity in the presentation of this part of the study.

Evidence

In order to evaluate whether there was an abnormally high number of alcohol-related deaths in the CDE group, the reader must consider at least two important matters: (a) death rates among alcoholics are apparently higher than among the population at large, and (b) the appropriate comparison group (to see whether the Sobells' CDE subjects were more likely to suffer alcohol-related deaths through 1981, as reported by Pendery *et al*) is the Sobell control group consisting of subjects who received standard hospital treatment with abstinence as the goal. The Committee noted that Pendery *et al*'s report of deaths in the CDE group was not substantially different from the death rate for such follow-up studies as the Rand Report (J. Michael Polich, David J. Armor, and Harriet B. Braiker, *The Course of Alcoholism: Four Years After Treatment*, John Wiley & Sons, New York, 1980). More importantly, the Committee noted that Pendery *et al* failed to report that six of the 20 relevant *control* subjects (receiving standard, hospital, abstinence-oriented treatment) also died within this same period, four of which deaths are classifiable as "alcohol-related."

ISSUE C

Were subjects randomly assigned to experimental and control groups?

The allegation is that random assignment of subjects to either an experimental or control group was not achieved because of factors such as bias in assignment and the purposive inclusion or exclusion of subjects into groups.

Findings

The Committee found no evidence of departure from randomization as undertaken and presented. The procedures used were consistent with the Sobells' claims. Allegations of shifting of subjects and purposive allocation to groups are not supported by other evidence and do not raise reasonable doubt as to the Sobells' integrity. There is no evidence of fraud.

Evidence

The Committee noted that the (significantly) earlier discharge from the study of the CDE subjects (as compared to the Controlled Drinking Control Subjects) was noted by the Sobells in a 1973 publication.

The Committee further noted that any sequence (such as the sequence of assignment to condition by hospital admission dates included by Pendery *et al* as Table 1 of their Article) can be the result of random process. In addition to the Sobells' own statements, the Committee examined accounts of former research assistants of the Sobells and a selection of hospital records. The Committee noted

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THE COMMITTEE: (Chairman) Dr Bernard Dickens, PhD, LLD, professor of law, University of Toronto; Dr Anthony Doob, PhD, director, Centre of Criminology, University of Toronto; Dr Harold Warwick, MD, professor emeritus, faculty of medicine, and retired vice-president, Health Sciences, University of Western Ontario; and Dr William Winegard, PhD, former president, University of Guelph (Ont), and past chairman of the Ontario Council on University Affairs.

'The Committee finds no evidence that the Sobells were lacking in scientific or personal integrity. . . '

Excerpts from the

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that the subjects understandably may have been confused as to how they were assigned to a particular condition. The assignment process involved first, a clinical judgment as to whether controlled drinking was an appropriate treatment goal for a given subject. After this decision had been made and communicated to the subject, a random assignment, by the flip of a coin, was then made, to determine whether the subject would be placed in the experimental group or in the group receiving routine, abstinence-oriented treatment.

The Committee also noted that former Sobell assistants remembered the coin-flipping procedure. It also noted that contemporaneous hospital records related to the Sobell study were less than complete or accurate, often not noting the exact treatment that subjects received. Given the overall lack of difference between the background characteristics of the control and experimental groups, and given the uniformity of the accounts of the non-alcoholics present at the time of the running of the study, the Committee saw no reason to doubt that random assignment had taken place.

ISSUE D
Did all the subjects meet the specific criteria of being *gamma* alcoholics?

The strongest allegation on this issue was not included in the published Article, and is that some subjects admitted to the experimental group of the Sobells' study "were demonstrably not *gamma* alcoholics" (Draft, p7). The issue the Committee addressed was whether the Sobells were fraudulent or deceptive in classifying four of the subjects as *gamma* alcoholics (whose classification is disputed by Pendery *et al*).

Findings
The Committee finds no evidence that the Sobells were lacking in scientific or personal integrity in presenting their assignments of subjects entered in the study.

Evidence
The classification of subjects as *gamma* alcoholics may be highly reliable if the level of alcohol involvement is very high. For some of those less involved, classification can be less certain and subject to individual judgment. The Committee reviewed the procedure followed by the Sobells (as described in their published reports and as elaborated to us by former employees of Patton State Hospital and the Sobells themselves), and noted that the classification was based largely on information that they themselves gathered for classification purposes rather than relying on hospital intake records. The Committee examined other published research done at the same hospital at about the same time and noted that these other researchers also gathered their own background data on their subjects rather than rely on Patton records. The Committee did not find it surprising, therefore, that Pendery *et al*, looking at hospital records, were able to find some subjects whose records did not include notations of factors that they thought were necessary for a subject to be classified as a *gamma* alcoholic. The Sobells used the hospital data and an independent medical assessment at the time of the study as well as their own assessment.

The Committee noted that this issue is probably less important than it would appear at first glance, since the design of the study involved a control group which, according to published data confirmed by the Committee, was in fact comparable. Indeed, the Committee, when it looked at this control group, readily found at least one subject whose background characteristics were as favorable as any in the CDE group and presumably would have been described by Pendery *et al* on the basis of these records as a non-*gamma* alcoholic.

ISSUE E
Were subjects and Collateral Information Sources (CISs) contacted as frequently for follow-up questioning as the Sobells claimed?

The allegation is that subjects and CISs were not contacted as frequently as claimed. The Draft by Pendery *et al* noted "a sharp disagreement between the frequency of interviews reported by the Sobells and that reported by the subjects and collaterals." The *Science* Article quotes the Sobells' claim that "each subject and as many respective 'collateral information sources' as possible were contacted every 3-4 weeks throughout the entire follow-up period," but does not present contradictory evidence. The Draft stated that 15 of the 18 subjects contacted by Pendery *et al* indicated that they had been contacted only one to four times in the two-year period of the Sobells' study.

Findings
The Committee finds that the Sobells did not achieve the frequency of follow-up contacts which they claimed. The Committee also finds the report by Pendery *et al* in the Draft to be wrong. Contact with subjects and CISs was considerably more frequent than reported by Pendery *et al* but less than reported by the Sobells. The Committee does not know whether the frequency of follow-up contacts affected the results of the study. The Committee concludes that the Sobells did not do what they said they did. They were careless in estimating a statistic they never calculated. There was, however, no evidence of fraud.

Evidence
The Committee noted that two types of contacts were attempted: with the subject himself and with any person or agency who might have information related to the functioning of the subject. These latter sources of data were referred to as "CISs" and the term is carefully defined by the Sobells. Pendery *et al* in the Draft appear not to have used the Sobells' published definition of "collateral information sources," since they imply that such a source was always an individual known to the subject. Part of the apparent discrepancy between accounts, then is that Pendery *et al* in their Draft did not use the same definition as the Sobells'. The Committee examined the Sobells' records for the CDE subjects carefully to determine how many times actual contact had been made between the Sobells and the subject and his CISs. It found that nowhere in the Sobells' written reports did there appear to be a report of the actual number of successful contacts although they do mention some difficulties. The Committee found that the Sobells had never counted contacts since their manner of data collection (reconstruction of drinking behavior of the subjects from reports of the subject and others using a technique they subsequently refer to as "time-line, follow-back" interviewing) did not demand it. Thus, when the Committee's count indicated that the Sobells had not been as successful in contacting subjects and CISs as they had reported, the Sobells were visibly surprised. The Committee concludes that in this matter the Sobells did not do what they said they did. They were careless in reporting their procedures and in the writing of their report. They did not go back to their original data (as the Committee did) to see exactly how successful they had been in contacting subjects and CISs. The Committee notes, however, that the Sobells made frequent contact with subjects where it was possible for them to do so.

ISSUE F
Was specific drinking information gathered in follow-up interviews?

This issue is not mentioned in the *Science* Article but the Draft alleges that "subjects and collaterals indicated that they were not asked for specific, day-by-day, drinking information."

Findings
The Sobells provided evidence based on the same research records as in Issue E that they had conducted, analyzed, and presented this part of their study with integrity, and offered clear evidence of conscientiousness. There is no evidence whatsoever of any misrepresentation on the part of the Sobells.

Evidence
The issue, in this case, reduces to a conflict between two sets of information. On the one hand, Pendery *et al* report that their subjects' memories of events six to nine years previously were that specific information was not gathered. The Sobells' data, on the other hand, demonstrate that specific information about amounts and types (at times as detailed as the size of the beer can or brand of wine) were recorded. These data were recorded (for the first year of follow-up in particular) in a number of identifiably different handwritings (including that of Dr Linda Sobell). Both Dr Linda Sobell and those other people whose handwritings appear in the Sobells' data confirm the accuracy of the data collected during the first and second year of follow-up. The Committee examined these records and it is clear that much specific, detailed, day-by-day drinking information (for those days the subjects reported drinking) is included. As already noted, these were the same data used to assess Issue E. The Committee found no reason to doubt the authenticity of these research records. The hypothesis that the data that were examined do not constitute contemporaneous accounts of subjects' reports is hard to maintain given the corroborative evidence of people other than Dr Linda Sobell.

ISSUE G
Did the Sobells lack integrity in their process of communication with subjects and their individual collaterals regarding the study of Caddy *et al*?

A condition of approval of the Caddy study was that the Sobells obtain the agreement of subjects to participate. Caddy *et al* reported that all patients had given their prior approvals to the Sobells. The Pendery Draft stated that this was not the case. The *Science* Article does not address the Sobells' acquisition of subjects' consent.

Findings
The Committee finds that the Sobells acted as the Research Advisory Committee of Orange County department of Mental Health required them to act, and that they behaved compatibly with scientific and personal integrity. Further, the Committee finds no misrepresentation, by the Sobells, of the procedures followed.

The Committee did find an inconsistency between the procedure followed by the Sobells and the description of it by Caddy *et al* which appeared about five years later. This discrepancy, however, reflects neither on the integrity of the Sobells nor on the validity of the Caddy data. Caddy *et al* appear to have been mistaken on one point related to the certified letter sent by the Sobells to each of their (former) subjects.

Evidence
The Committee examined photocopies of certified mail receipts of letters sent by the Sobells to their former subjects. In addition, it noted that the only evidence put forward by Pendery *et al* related to this allegation were the statements of subjects made years after the time in question. The Committee examined the minutes of the Research Advisory Committee with respect to this issue, copies of the letters the Sobells sent to subjects and individual CISs, and a number of responses that they received to the letters. That all subjects did not recall this contact is not surprising in the opinion of the Committee since the contact involved one letter from the Sobells and then a single interview from the Caddy *et al* team.

ISSUE H
Was the Caddy *et al* study conducted as claimed, regarding interviews with subjects and individual collaterals?

The Pendery *et al* Draft states that Caddy *et al* did not carry out the follow-up study in the manner reported. The issue is not addressed in the *Science* Article.

Findings
The Committee concludes that the Caddy *et al* study was carried out essentially as described, and that there is nothing to cause the Sobells' integrity to be questioned with respect to their association with the Caddy study.

Evidence
The Committee was given copies of letters from Caddy's original research assistants (students in a university course). Some of these students report not having read the Caddy *et al* paper (it appeared approximately four years after the end of the Caddy *et al* follow-up interviews took place). However, the description given by these former research assistants is completely consistent with the Caddy report.

It should be noted that Caddy *et al* relied completely on self-report data. Certain aspects of the self-reports were verified (eg incarceration days were verified where possible, p349), but it would

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The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

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appear that attempts were not made to search institutional records unless an incarceration was first reported by the subject or a CIS.

CONCLUSION

The Committee has determined that there is no evidence sufficient to raise reasonable doubt concerning the scientific or personal integrity of Drs Mark and Linda Sobell.

The charges made and implied with respect to the Sobells involve the most serious kinds of allegations it is possible to make against someone acting in the role of scientist. In this case, however, the Committee found itself in a peculiar position: the statement of the issues as published by Pendery *et al* in *Science*, when carefully read and literally interpreted, may not have cast doubts directly on the Sobells' integrity. On the other hand, many people did not appear to have read the published statements exactly as they were written, if they read them at all. Indeed, from statements attributed to the second author of the *Science* Article, Prof Maltzman, it would appear that the statements in *Science* were not meant to be interpreted strictly. The Committee found, then, that part of its responsibility in investigating the allegations against the Sobells was to make explicit the allegations implied by the *Science* Article and the earlier, well-circulated Draft.

In addition, the Committee found that one of its responsibilities was to make explicit the salient aspects of the Sobells' design and data that have been public, in the form of journal articles, for almost a decade. It appeared to the Committee that few people, particularly those responsible for media accounts of the dispute, took the trouble to see if the hospitalizations of CDE subjects within the first year after treatment, detailed by Pendery *et al* in their *Science* Article, were reported accurately by the Sobells in their 1972 and 1973 publications. They were. But by sub-titling their 1982 Article "New findings . . ." Pendery *et al* may have convinced readers and those who simply heard about the paper that the data had not been reported before.

Similarly, by choosing not to compare the CDE subjects' outcome with data from an appropriate control group, Pendery *et al* implied that the long-term prognosis of the CDE subjects was worse than would have occurred with routine treatment. No form of treatment of alcoholism known to the Committee is clearly perfect for any group; hence comparisons must be made of treatment groups in order to evaluate any particular treatment. This is, of course, the nature of the design the Sobells used: for each experimental group, there was an appropriate control group.

Pendery *et al* have reviewed some of the Sobells' evidence relating to subjects in the CDE group and have gathered further evidence of their own from the same subjects. This latter data gathering took place eight or more years after the subjects participated in the study. Pendery *et al* also present life-history information about these subjects for periods of time extending several years beyond the time when they were being studied by the Sobells and by Caddy *et al*. From their investigation, Pendery *et al* conclude that the outcomes for the controlled drinking patients were not favorable.

Pendery *et al* do not, however, compare group outcomes. Without comparisons of any kind, we are left, for example, with tragic stories (played up by the mass media) of four CDE subjects' deaths (relating at least in some cases to alcohol). Deaths are often tragic. As unpleasant as they might be, however, drawing inferences from them with respect to treatment effectiveness *demands* a comparison. Science, the activity, would have demanded such a comparison even though *Science*, the magazine, did not.

Ultimately, the goal of scientific study of alcoholism is not well served by disputes such as this one. It is unreasonable to base any treatment program on the results of one study. The Sobells' study should be regarded as but one set of data among many sets in the scientific literature comparing types of treatment.

EPILOGUE

General observations arising from the enquiry

Beyond the particular issues regarding the Sobells, a number of matters have come to concern the Committee which transcend the immediate enquiry. We want, in conclusion, to address a number of these matters, since we believe it appropriate to draw them to the attention of the community of scientific researchers upon human subjects.

The retention of data

The Committee has spent many days from June to late October, 1982, inspecting a sizeable number of documents, many of which were dated more than a decade earlier. These were maintained in fastidious detail which at moments bordered on the obsessional, such as in the filing of personal Christmas cards and envelopes. Had data of this age and detail not been preserved and transported across the continent from Patton State Hospital, Ca, through two homes elsewhere on route to Toronto, (Ont), no response of any credibility could have been made to the most fundamental charges scientific investigators can face in their careers.

The physical storage and maintenance of data present a logistical and financial problem which both individuals and institutions must face. Certain records in the possession of Patton State Hospital were destroyed in the routine course of institutional housekeeping, which may have compromised a defence to a serious ethical charge presented several years later. Hospitals have legal duties of maintenance of clinical records which can extend, where a child for instance is concerned, for up to or beyond half of a century, as in Ontario, depending upon whether data are kept in documentary form or, for instance, in photograph or microfiche. A hospital, clinic, or other facility where research is undertaken may, however, distinguish between clinical records and non-clinical research data, not least in order to limit storage duties which are costly to service. Where investigators have personal charge of data, furthermore, issues may arise of ownership (at one point the Sobells were described as having stolen Patton State Hospital records), and of associated duties of preservation.

Beyond legal duties of record maintenance, however, are the interests this enquiry has observed of all investigators scrupulously to preserve all documents and other evidence of fidelity to their research protocols, lest charges of ethical, methodological, or other wrongdoing may be made to which it is no longer possible to present responses supported by critical evidence. Researchers destroy, surrender, leave behind, and misplace data at peril of their reputations and careers.

A further problem arises where a research-team's members go in different directions upon completion of a project. Each member may need to ensure access to all of the data, both for individual means to explain procedures and demonstrate integrity, and for satisfying that member that other members acted honestly. Where doubts arise as to former colleagues' integrity which cannot be resolved, an individual may consider his or her professional reputation to be at the mercy of what inaccessible data may disclose, and may accordingly determine upon public and professional dissociation from the co-authored publications. The integrity of such publications may later be vindicated, but an innocent collaborator with fraudulent colleagues may have no means other than dissociation to show that he or she was a victim of the betrayal, and not a partner in the perpetration of fraud.

Clearly, it may be preferable for colleagues undertaking different parts of a joint study to show the integrity of their individual work at the time it is done, and to be vigilant of both the competence and honesty of collaborators' endeavors. A cost of fraud in science, however, is not only the introduction of self-defensive mutual suspicion into the interactions of colleagues, but the limitations it may impose upon integration of efforts of colleagues who bring different disciplines, skills, and methodologies into an enterprise, since one colleague cannot duplicate the work of others, nor monitor it with the ability to detect fraud, such as fabrication, deliberate bias, or misrepresentation. Nevertheless, the precondition to identification of impropriety may be common access to pooled and preserved data. This may represent the only insurance an investigator may have against betrayal by necessarily trusted colleagues, and against damage done by later charges of error and dishonesty. It may be emphasized that investigators in common enterprises have mutual interests in ensuring preservation of, and access to, all of the data from a study, for as long as it may fall under suspicion.

Confidentiality and adverse interests

Research subjects' confidentiality may best be preserved by destruction of data, including codes of identification, audiotapes and videotapes recording interviews and interactions, transcripts of tapes and, for instance, responses to questionnaires. It has been seen, however, that data destruction jeopardizes investigators. Thus, the preservation of subjects' confidentiality may be inimical to preservation of investigators' reputations. An ethical requirement increasingly emphasized by professional associations and, for instance, institutional review boards considering protocols proposing research on human beings, has been that investigators must act as guardians and protectors of their subjects' confidences. Discharge of that role is compromised when investigators have an adverse interest in maintaining means of relating particular data to individual research subjects, and in revealing such personalized data when faced with a charge against their personal integrity.

The Sobells showed the Committee sizeable amounts of personal information upon subjects identified by full name, photograph, family history, successive addresses and occupations, including spouses' descriptions of distress and, for instance, devastation of their marriages. We saw this information in confidence, but the harm to individuals can easily be imagined had the tribunal met in public and conducted its affairs by adversarial techniques in the presence of newsmedia. The sacrifice this might impose upon subjects' confidentiality is self-evident, even if identities were not given publicly.

Committee members who have served on institutional experimentation review boards which have required investigators to protect subjects' confidentiality by destruction of personally identifiable data and, for instance, keys to codes, have come to feel some apprehension about thereby exposing investigators to charges of fraud which they lack effective means to answer. Further, such destruction of data may actually be a means of perpetrating and concealing fraud. Not only do investigators have an adverse interest in the destruction of confidential information on research subjects, but the research community itself may have an adverse interest in destruction of means to detect and expose scientific fraud. Maximum preservation of subjects' confidentiality is thus shown to be dysfunctional to the integrity of the research enterprise at both individual and general levels.

Undertakings of confidentiality made to potential research subjects of whom personally identifiable data will be kept are always less than complete guarantees, since files may not resist the force of a subpoena. If a charge of scientific fraud were to result in criminal court proceedings, civil proceedings such as for breach of the investigator's contract, or for defamation of the investigator by critics, court orders might make confidential documentation available beyond the circle of those bound by undertakings of confidentiality given to subjects. Further, if professional disciplinary proceedings were to arise, for instance against investigators or against critics alleged to have acted incorrectly and unethically, need may arise to consult research documents. Our own enquiry was in a sense a predictable consequence of investigators being accused of fraud. It may be trusted that the less public an enquiry is, the more protection can be afforded to confidential data, but court proceedings and certain disciplinary proceedings may be held in public, and newsmedia have legitimate rights of publication of proceedings.

It may be that, when potential research subjects are initially approached and invited to participate in a study, these necessary limitations upon assurances they are given of confidentiality should be made more explicit. They should not remain merely implicit in guarantees to ensure "maximum confidentiality," or to safeguard confidences "to the limits allowed by law," or as provided in comparable standard expressions. Guarantees which are now given to destroy means of personal identification may, of course, be preserved, but our enquiry shows the undesirability of data destruction, for protection of the integrity of both the individual investigator, and of scientific research itself.

Underfunded studies

The fact that the beginning of the Sobells' second-year, follow-up study was not externally funded, and was supported only from the investigators' personal means, had consequences discussed in this report. Resulting publications did not address this issue, and were not required to do so. Similarly, initial stages of the investigation resulting in the Draft and the later Article in *Science* were apparently funded

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from the primary investigator's own means. It is honorable and consistent with devotion to their science that investigators should pursue research at their private cost.

Nevertheless, insufficient funding of studies may impoverish them in ways which affect methodological rigor, the clarity of ethical integrity, and ultimate credibility. A shoestring budget is no more evidence of poor science or integrity, of course, than an affluent budget is a guarantee of good science and sound integrity. Information about the resources of finance and of the time it may secure which have been dedicated to a research project may, however, offer some useful means of additional assessment of its method and conclusions, and serve notice to the audience which resulting publications address that the research means applied were limited in described ways.

Existing practice is to disclose agencies whose grants have supported studies. This properly acknowledges their dedication of public, private, or charitable funds, and may give prestige to studies because of their ability to gain such support. The budgets secured by grants tend not to be stated, however, perhaps for good reason. Where principal investigators' salaries are paid by academic or other employers, external funding of support staff, research equipment, computer time, or, for instance, travel expenses, may not disclose the total sum of resources which have gone into a study. Expensive studies may require only relatively marginal external funds. It may be, however, that all studies should offer some adequate although brief indication of the financial means by which they were conducted, going beyond a simple acknowledgement of contributing agencies. This point addresses only revelation of total resources applied to a study, and leaves open the question of whether anonymous support or sponsorship ought to be permitted, or whether the actual agencies which award money to a research project should have to be named in publication of its results. This raises issues of possible sponsor bias, and of perhaps charitable front agencies masking commercial, political, or other organizational sponsorship, but no concerns in these areas arose from the present enquiry.

The prospect of reduced resources being available for research may direct potential investigators toward non-traditional sources of support whose own goals and motivations in offering sponsorship may present issues which have not been faced before by professional bodies in any authoritative or normative fashion. Further, the dilemma will become more acute of whether it is better for the progress of science that studies be undertaken inadequately rather than not at all. We may have to consider a variant of an old adage, and ask whether, if something is worth doing, it is worth doing badly. The experience of the present investigators shows not that they conducted research badly, but rather that they did the best they could under difficult circumstances. However, if the difficulty of their circumstances had been more obvious, the constraints under which they were acting would have been more apparent. This would not have diminished the value of their work, but would have indicated its context and permitted a realistic evaluation of its worth. These observations apply, of course, to the studies we have considered both of the Sobells and of Pendery *et al*, since we found our concerns to arise from a general rather than any specific interest in the presentation and interpretation of research data.

The method of making and resolving challenges to integrity

A remarkable feature of the setting of our Committee's functioning was that we were appointed after a period of mounting rumor, but some time before publication of the Article in *Science*. This had been presented in anticipation as exposing a "fraud," a "scandal," or at least a "refutation." The published Article did none of these things, and claimed to do none, although it did raise issues of major concern worthy in part of the volume if not the nature of attention it received. The early Draft of the eventual, but significantly different Article circulated very widely, along with other critical documentation much of which came into the Committee's hands through the Sobells, when distributed informally by newsmedia people and others. In anticipation of publication of the *Science* Article, sometimes sensationalized newspaper features appeared in such journals as the *San Diego Union*, *Los Angeles Times*, *Toronto Star*, *Ottawa Citizen*, and, for instance, the *New York Times*, and documents have shown how a sponsor of the Pendery *et al* study advised upon a press campaign aimed to maximize public impact of the Article.

In modern times one cannot be elitist or even overly fastidious about how scientific allegations are made, not least when public funding has been involved in research and the effects of studies are of concern to the community at large. Further, the press and other media have a legitimate and important function in the researching and publication of stories of public note, which scientific controversy and allegations of scientific fraud certainly are. Nevertheless, it may be of interest to consider how some professions require the presentation of research data. The profession of medicine, which may be most closely analogous to the discipline of psychology practised by the Sobells and Pendery *et al*, expects the results of research to be offered for the assessment and criticism of professional peers before they are more widely advertised. The editorial principle of the highly presitigious *New England Journal of Medicine* to refuse to publish an article whose results had previously been described in public may be questioned as a rather extreme reinforcement of this principle, but it underscores the professional view that discourse among medical scientists is expected not to originate as did the Pendery *et al* challenge to the Sobells. We have no evidence that authors of the original Draft promoted its circulation in the way that occurred. Further, we leave to the profession of psychology the determination of ethical requirements of circulation and publication of research data. We question, however, how satisfied the profession and others may be at the grapevine rumors which grew into a jungle of accusatorial and counter-accusatorial documentation alleging investigator bias and worse against the Sobells, Drs Pendry, Maltzman, and others, all preceding publication of the actual Article in *Science*, and distorting its meaning even among professionals.

It appears that a better means is needed than obviously exists to receive complaints of defective integrity in studies, and to resolve such complaints credibly to the satisfaction of reasonable people. The need for a mutually acceptable means is particularly acute where doctrinal conflicts and different philosophical orientations are present, such as exist regarding proper goals of treatment programs for *gamma* alcoholics. The self-regulatory status of professions differs between jurisdictions, but a duty of self-policing may be more uniform so that practitioners of the same discipline can present complaints of others' work in a professional manner, and reach agreement or have an arrangement imposed upon them as to the means of reasonably prompt resolution of such complaints. This duty is owed both to the individual members of professions, and to a concerned public.

Prevention of scientific fraud

The thought is not original that prevention or at least reduction of fraud by visible procedures is to be preferred to its subsequent exposure, and to the suspicion that it has been practised whether adequately exposed or not. The Committee observed and endorses in principle the suggestions made in January, 1982 by the Ad Hoc Advisory Committee to the Dean of the Harvard Medical School on Dishonesty in Scientific Research. The Ad Hoc Advisory Committee's suggestions were not directed to the discipline of psychology, but we believe that they may be applicable in the following terms. They are relevant to studies purporting to challenge earlier work, of course, no less than to the original work itself.

1. Special attention should be given at the time of recruiting staff to a project to the motivation and integrity of the applicant through careful examination of credentials and claimed accomplishment.
2. Written, detailed, explicit procedures for data gathering, storage, and analysis are essential and should be available in the research centre.
3. Junior and intermediate researchers should be supervised by experienced scientists, including regular, in-depth scrutiny of the primary data and the calculations leading to the presentation of results. The research director should, by example, develop in colleagues a respect for primary data and their preservation.
4. The conduct of studies including interviews which are blind to subjects' conditions or coded, and the exchange of methodologies between research centres, should be encouraged. The repetition of studies or of data interpretation by different research teams is desirable whenever possible.
5. Junior and intermediate researchers should be encouraged to work with other colleagues, to share data, and to engage in free discussion of results. Secrecy about methods and data should be discouraged.
6. Emphasis should be placed upon the quality and significance of research rather than on quantity and visibility. The research or unit director should accept responsibility for the quality of the work reported from the research centre.
7. There should be close personal interaction between researchers at all levels of seniority. Among the many benefits of such close interaction could be the early detection of personal problems or unusual personality traits.

These suggestions may be reinforced by, for instance, introduction of systems of unannounced spot-checks upon data by independent and perhaps senior scientists, and by investigators having to recognize their enforceable accountability to colleagues, independent experts, and their employers, not only for their competence, but also for their integrity. They may no longer expect to be trusted merely because they consider themselves worthy of trust. While it may be unconvincing to argue that a specific challenge to personal and scientific integrity is not stigmatizing, it is clearly proper and necessary that conscientiously formulated challenges to integrity should be expressed in good faith, and be subjected to appropriate means of resolution.

The law provides a model of management of suspect relationships. In dealings between unequal partners, such as between lawyer and client, physician and patient, and, for instance, priest and penitent, where one party has the power afforded by superior knowledge, the law presumes that any benefit to the more powerful party (beyond a conscionable fee) has been procured by the exercise of undue influence. Accordingly, the courts will render a benefit such as a bequest in favor of a lawyer, physician, clergyman, or church void, unless the beneficiary can discharge the burden of showing that the benefactor had access to such independent advice as would neutralize any undue influence which may have been consciously or unconsciously applied. To the set of inherently suspect relationships we may add that of investigator and subject, and the voided benefit may be composed of the research data and resultant publications the investigator acquires. The investigator must discharge the burden of showing the integrity of acquisition and presentation of data. Independent spot-checks and other means to underwrite the ethical integrity of a study, particularly when it is unlikely to be replicable, should therefore be welcomed, rather than resented as a stigmatizing intrusion.

The need for independent senior researchers to monitor studies by spot-checks and by inspection of submissions of evidence of integrity made by the investigators relates uncomfortably to the issue of underfunding. It may be asked whether investigators must add to their budget application an item to provide for specialist monitoring of ethical integrity. An alternative may be that institutions willing to engage investigators, or willing to permit their staff to undertake research and to publish results disclosing their institutional affiliation, thereby both invoking the prestige of the institution and also potentially contributing to it, should provide this service as a basic precondition to pursuit of research. This may not necessarily involve them in prohibitive expenditures, depending upon their circumstances. University-based centres have research protocols reviewed by institutional review boards whose members are usually unpaid, and consider themselves to be rendering a service to the university. Administrative costs may be involved, of course, which may be attempted to be recovered from successful applicants for funding through appropriate budget items, but this is not uniform, and often monitoring agencies will absorb these expenses themselves.

Involvement of additional people such as independent monitors who subscribe to the integrity of a published study offers a greater assurance of its regularity, but not a complete assurance. The monitors may be uncritical, casual, or simply overextended. Further, they may be accused of serving personal or institutional allegiances. Those suspecting that conspiracy may have been added to fabrication or other fraud need never close the net of conspiracy, which may embrace investigators, monitors, subsequent review committees, and more. This issue relates to point 4 above on means to resolve challenges to integrity, and has added impact where doctrinal differences exist within a field of practice or research, since the most prestigious of even national bodies may fall under suspicion of deliberately or inadvertently biasing a review procedure in favor of one perspective or approach. Although suspicions of this nature may contribute to an erosion of general professional and public confidence, they may not be entirely bad. They may also provide a spur to recognize that preventive measures must not only be effective, but must also achieve some level of objective credibility. Such preventive measures against fraud would not only buttress the studies in which they are taken, but contribute to professional and public confidence in the enterprise of scientific research.

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Benzodiazepines

Benzodiazepines

Benzodiazepines

Benzodiazepines

Benzodiazepines

Today

Since their appearance in the 1960s, members of the benzodiazepine family of anti-anxiety drugs, minor tranquillizers, have been taken by an estimated 500 million people around the world. While many doctors and patients have found the drugs beneficial, there has also been intense debate about such massive use of the drugs and about their addictive properties.

To review the history, prevalence of use, clinical findings, and public and professional attitudes, a four-day conference on *The Benzodiazepines Today — two decades of research and clinical experience*, was held recently in San Francisco. It was sponsored by the Haight-Ashbury Training and Education Project; the California Society for the Treatment of Alcoholism and other Drug Dependencies; and the Benzodiazepine Research and Physician Training Project. Harvey McConnell reports in a two-part series. This month: a round-up of views from some of the 22-member expert faculty at the conference. Next month: the controversial use of the benzodiazepines in treatment of alcoholism.

Dr David Smith (MD), chairman of the conference, and director of the benzodiazepine research and physician training project, Haight-Ashbury Free Medical Clinic, San Francisco, Ca: With any drug there is an interaction between the physical characteristics of the individual, the psychological characteristics of the individual, and the social and cultural environment in which the drug is taken, he said.

"Development of the study of chemical dependence has clearly stressed that people react differently to drugs. The question of overprescribing suggests everybody reacts to a particular drug in the same way. In fact, the evidence is quite the opposite.

"People react differently to drugs. What may be appropriate prescribing for a majority of the population may be inappropriate to a minority of the population which has the psycho-biological predisposition to addiction. This is the area which has caused so much of the controversy."

Dr Bruce Medd (MD), assistant vice-president and director of marketing and professional services, Hoffmann-La Roche head office, Nutley, NJ: In the case of the benziodiazepines in general, and Valium (diazepam) in particular, "never in the history of the industry has there been a product that has drawn more attention from the medical community, the political arena, patients, public, and the media."

In the case of Valium, no other pharmaceutical has had more written about it in the medical, pharmacological, and lay press, and in the theatre, movies, and television. Never have so many well-known personalities claimed potential risks associated with (a pharmaceutical).

"Conversely, no product can claim the widespread, safe, and effective use, as documented by the scientific literature and countless millions of patients, over the past 20 years."

Dr Edward Tocus (PhD), chief, drug abuse staff, United States Food and Drug Administration (FDA): "The use of minor tranquillizers is reported to be approximately equal to the prevalence of anxiety. There is also data which suggest there is a sub-population which is undergoing psychic distress who may be under-medicated."

The question of overprescribing remains under debate, and depends somewhat on the limits which are considered justifiable, he said.

Public health and social problems associated with the benzodiazepines are difficult to quantitate. It is the opinion of a committee of outside experts who advise the FDA that there is no one compound in the group which could be singled out as having a greater or lesser public health risk. When used at therapeutic dose levels, "these drugs are remarkably safe, reflecting their excellent therapeutic index," Dr Tocus added.

"It is readily apparent they are much safer drugs than any other class of drugs or individual drug which can be used for the same indications. There is a remarkable lack of morbidity and no known organ damage associated with even high doses over a long period of time. Mortality data reflect this relative safety.

"However, the risk rises significantly on all parameters when a second central nervous system depressant and/or alcohol are introduced."

Epidemiological studies demonstrate that a majority of patients receiving the drugs have high levels of psychological distress and high levels of life-change crises. Even among this population as a whole only about 30% are actually receiving treatment, he said.

"The benefit-risk ratio of this class as a whole is considered very favorable. At the same time, we need to know as much as we can about their use and misuse."

Many of the problems with the benzodiazepines, as well as other drugs, can be traced to improper use by patients. Several reviews of the literature have shown, in many cases, large portions of the patient population do not adhere to the prescribed regimen: they take too much, or too little, prematurely discontinue taking the drug, or take doses improperly.

"Although there are many reasons for this, I think a big proportion of the problem can be traced to inadequate communication between the doctor and patient."

Dr Stanley Gitlow (MD), clinical professor of medicine, Mount Sinai School of Medicine, New York: "Without the benzodiazepines we might not have linked a potential common mechanism for hypnotic, central nervous system action."

Drugs cannot be justified for lowering the symptoms or the signs of the illness. "Only if they improve definitive function or lower morbidity or mortality: if you don't have that, then you have no legitimate use.

"The fact it takes away a symptom is not a legitimate use for a drug."

Dr Gitlow said that just as only 10% of the people who use alcohol get into trouble of one sort or another, only a small group gets into difficulty with the benzodiazepines, often not by becoming addicted but by what the drug does to them.

In some patients, there is increased recidivism, which is the result, in part, of a decrease in self-confidence, and, in part, of intermittent increased psychomotor activity, even with chronic use.

Dr Glen Mellinger (PhD), executive director, Institute for Research and Social Behavior, Oakland, Ca, has carried out studies for the US National Institute of Mental Health in 1971 and 1980. They have shown that prescribing in general has been declining (**The Journal**, Sept).

"Public attitudes toward tranquillizers have been strongly influenced by extensive mass media coverage.

"The long-term Valium (diazepam) user has come to be represented by the overly-ambitious, frenetic, career woman burning the emotional candle at both ends. This portrayal is culturally revealing, I think, because our studies have found the public attitude toward tranquillizers has a strong, underlying, moralistic component.

"A portrayal such as this perpetuates the not-uncommon view that the use of tranquillizers is a sign of personal weakness, if not downright turpitude."

Dr Mellinger said the study was of 3,161 individuals in a cross-sectional investigation which had a high return rate and was nationally representative. They studied long-term users, abusers, and non-users of tranquillizers.

Long-term use was defined as daily use for a year or longer. Results indicate that such use is relatively rare, occurring among only 15% of users.

"Contrary to one stereotype, the results showed that long-term users are distinguished mainly by being older, by having high levels of emotional distress, and, most of all, by a multiplicity of health problems, especially chronic conditions.

"Contrary also to popular stereotypes, stressful life events did not appear to be implicated as a major factor in long-term use."

The 1980 study found that 11.1% of the adult population between 18 and 74 years of age received medication in the benzodiazepine class at least once in the previous year. This figure is almost identical to the one obtained in 1971.

Among those who use anti-anxiety agents, 45% use them on one or two occasions, or a day or two at a time, but never regularly. In addition, 62% use them for less than two weeks on a regular basis, and 80% for less than four months.

Fifteen per cent of the users have used benzodiazepines for more than a year: 3% for three years or more, 6% for three to seven years, and 6% for more than seven years.

Dr Mitchell Balter (PhD), chief of applied therapeutics and health practices program, US National Institute of Mental Health, said Dr Mellinger's study "makes it very important to remember that users of benzodiazepines represent only 1.6% of the general population."

One of the major problems with the benzodiazepines was the rapid acceleration of their use when they first appeared in the 1960s. "Moral indignation seemed to grow" amid the feeling things were just going too fast.

Then came the feminist movement; many members felt that to be drug-treated was a form of slavery, and to go to the doctor was to go to the enemy. This was followed by the growth of the consumer-safety movement and the idea that people have the right to choose, and drugs may be dangerous, said Dr Balter.

"While nobody was looking," prescribing patterns by doctors began to change and the number of prescriptions written for all drugs had dropped 32% between 1973 and 1980.

He said this conservative behavior on the part of the doctor and patient is admirable, "and I like it because it came without controls. In the past, there was too much excess medication but this seems to have been corrected by the medical community.

"At the same time, there is a new attitude. Many people fear the drugs and they still believe doctors are overprescribing. There is now a cultural collusion: the patients want to use them for a shorter period of time and it is in the interest of the medical profession to do so."

Indications are most of the benzodiazepines are prescribed by primary-care physicians and are given to regular patients, not new ones.

As for long-term users, "they certainly don't meet any stereotype of the classic drug abuser.

"They are an older group of people — 71% are over the age of 50, and 60% are women. So you are dealing with the older woman, who certainly is not your typical stereotype who enters an addiction or dependence program."

He said Dr Mellinger's studies and other data gathered by the institute indicated a conservative trend in prescribing patterns "and this is why the profession and the media were caught out because this phenomenon was changing while nobody was looking."

Dr Leo Sternbach (PhD), discoverer of the benzodiazepines, and now retired as director of medicinal chemistry, Hoffmann-la Roche, is firm: "A chemist cannot predict addiction."

Dr Sternbach, a native of Poland who went to Switzerland in 1940, and to the US in 1941, said that in the 1950s he started working with a group of compounds he had experimented with in the 1930s in Poland.

"I did not submit them to pharmacological testing at that time, but later I did, and we found some very interesting pharmacological properties."

Dr Sternbach believes his discovery is tremendously useful and the great controversy is about a small number of people who have gotten into trouble.

"Now, the benzodiazepines are not used in cases where they really could help because the doctor or the patient is afraid.

(continued on page 12)

'The public attitude to tranquillizers has a strong, underlying, moralistic component . . .'

'The aim is not to get rid of all anxiety but to get over the hump . . .'

(from page 11)

These drugs will still be useful when this furor dies down."

Dr Sternbach does not believe the controversy will inhibit basic chemical research.

Dr Leo Hollister (MD), senior medical investigator, Veterans Administration Medical Center, Palo Alto, Ca, said he has preached for years that the benzodiazepines "should only be used for good indications, and this is particularly important in the management of the patients with anxiety."

On the one hand, "all of the people who are anxious don't need to be treated with drugs. Adjusting to change is part of the normal process of living."

On the other hand, "there are patients who are terribly uncomfortable with their anxiety and are quite often disabled. It seems to me that the two critical judgements which have to be made are how disabled they are, and how uncomfortable they are."

Other indications for the benzodiazepines include promotion of sleep, though this is a matter of clinical judgement for the doctor. At Dr Hollister's medical centre, most of the compounds are prescribed by neurosurgeons for muscle relaxation, and this appears to be a valid indication.

There are clear indications for their use in seizure crises. "Treating alcoholics with these drugs is becoming really controversial, and, again, it is a matter of clinical judgement, but it seems their use can be valuable."

But the doctor must constantly assess the efficacy of benzodiazepine use by patients.

"I mean very early on. If a patient has been treated with an adequate dose of these drugs, and has not responded in a week or two, I always begin to get my guard up, and I ask myself if I have made the right diagnosis.

"The reason for this is that the most misdiagnosed disorder of anxiety is depression. The patient's depressive syndrome — no matter what kind of depression you have — has as much anxiety as it has depression, and it has also a lot of tension, and a lot of complaints ordinarily associated with anxiety.

"It is very easy with the depressed patient to think he or she is suffering from anxiety, and you give them an anti-anxiety drug and you find it doesn't relieve them. In fact, the proper treatment should have been an anti-depressant.

"The aim is not to get rid of all anxiety, but to get them over the hump, and if we can do that, we know the future can be treated effectively. But if we continue to treat indefinitely, they might become more tolerant to the drug and become dependent on it."

Doses must be adjusted individually, Dr Hollister said: "If there is one thing we have learned from pharmacokinetic studies, it is that people are different, they are all heterogeneous. The problem is how to determine the right dose for the right person."

The final principle in using the drugs is gradual discontinuation. Dr Hollister said if these guidelines are followed "one can use these drugs quite safely and quite effectively."

Dr Karl Rickels (MD), professor of psychiatry and pharmacology, University of Pennsylvania, Philadelphia, said his long-term studies of the use of benzodiazepines for anxiety show "they are better than placebo, but they are by far not a panacea. Improvement does not occur in everyone."

There might be improvement in 70% of patients treated, but not all of them will reach "normative levels."

"Straight anxiety might be susceptible to pharmacological intervention, and it may not be susceptible to anything. From every indication available today, these drugs do not help every patient."

It is important for the doctor not to lead the patient to believe that the benzodiazepines will do everything for him. "Frequently, if you limit the expectation of the drug, you get a better result."

In treatment, it is important the patient realize his problems are emotional. Results are poor in using the drugs for those patients who expect psychotherapy, said Dr Rickels.

"What happens in the first week of treatment is very important in predicting what will happen later on. Certainly, if you don't see anything in a few weeks with a benzodiazepine, then forget it and go to something else, because the patient will just not respond."

In a long-term study with diazepam, Dr Rickels and colleagues found that if the patient did not benefit within six weeks there was no sense in continuing the drug. "I have seen patients who have been on drugs for years and they are not doing very well."

Conversely, those who did do well in six weeks were maintained for six months, tolerance did not develop, and none of the patients needed an increased drug dosage. A follow-up a year later showed they had done well on the drug.

He finds today that patients who did well on the drugs previously, and may need them again for a short period, "through media hype are afraid to go back to them, and I find this a very disturbing factor."

Dr Anthony Kales (MD), professor and chairman, department of psychiatry, and director, The Sleep Research and Treatment Center, Pennsylvania State University College of Medicine, Hershey, Pa, said the benzodiazepines can prove an adjunct to overall treatment of patients with insomnia.

Research has shown that about 20% of the population has sleep problems, but this is a multi-dimensional disorder: the patient's situation, physical condition, and depression can all play a part. Physiologically, the older people get, the more difficulty some have in going to sleep.

Careful assessment and diagnosis is needed with patients who have a sleep problem, and a drug history needs to be taken. While the benzodiazepines can be an adjunct, decisions must be made on an individual basis.

Dr Julie Botvin Madorsky (MD), Casa Colina Hospital for Rehabilitative Medicine, Pomona, Ca: In the past, diazepam has been used fairly indiscriminately in treating muscular spasms, "but now we have enough indications about its actions that we can be precise and careful and successful in its use."

Studies have shown diazepam is not more effective than acetylsalicylic acid (ASA) in acute musculo-skeletal syndrome such as, strains, pains, or cramps. Nor is it likely to be of help in the treatment of the symptoms of primary muscle disease, such as muscular dystrophy, she said.

"However, they should be used for spasticity in central nervous system disease. This has now been well documented and diazepam is one of the most commonly-prescribed compounds for spasticity, such as cerebral palsy and spinal cord injury."

Dr John Chappel (MD), professor of psychiatry, and a teacher in alcohol and drug abuse, University of Nevada, Reno: Professionals in the medical field need to be educated about drug use. "And we doctors need to be educators with our patients. All too few of the doctors graduating from our current medical system know how to teach their patients, and we tend to repeat the way we were taught."

The doctor has a tremendous amount of control at his disposal, and this means he can control doctor-patient relations. "But we certainly ought to be able to share control, because studies have shown that when this is done, there is better patient compliance and a better improvement of organic illness, and not simply the emotional and psychological problems.

"We need patients to understand what is going on, to get a rational explanation from the doctor, and experience participating in a process and taking some responsibility for their illness.

"We need to share control and make the patient a responsible partner."

Dr John Morgan (MD), professor of pharmacology, City College of New York — and colleagues have started examining a huge library of newspaper and magazine articles, television presentations, and cartoons from throughout the benzodiazepine era. So far, they have analyzed 124 articles on anti-anxiety drugs published between 1954 and 1980.

"Historical attitudes toward drug use in the United States have remarkably influenced patients and doctors in their general attitudes toward drugs," he said.

In the case of the benzodiazepines, there has been a pronounced negative shift against the compounds. "We have found that the least favorable or balanced articles about the benzodiazepines appeared in 1964 and 1965. In the last 15 years most of the articles have been increasingly negative."

In the mid-1970s there was a hue and cry about dependency and withdrawal; then about the use of the benzodiazepines and alcohol; in the late 1970s the emphasis was on the "manipulation of women" with the drugs, said Dr Morgan.

"The criticism is moralistic in that a certain kind of drug use is wrong, and improper, and the writers seek justification to support this moral indignation."

The situation now is that human behavior is being described in two different ways: the moralistic way and the clinicians' way. The educated people who write for, and read, newspapers, are ambivalent about stating the moralistic, indignant viewpoint. "They tend to present, instead, the dangers of the drug, whether any danger has appeared or not.

"They focus on the individual because only by focusing on the individual can we provoke in people the sort of emotional response which embodies our response to a properly told tale with a plot, structure, and action."

If a story on Valium, for example, is presented with a plot "we will win the audience to position every time."

Dr Morgan and fellow researchers on the subject believe it is an accurate observation that most stories about drugs, and not just drugs in the benzodiazepine category, are presented in a superficial way.

Doctors are also a major target for lawyers, and many lawyers are looking for individual patients so that a suit can be brought for whatever reason.

Next month

Harvey McConnell reports on the controversial use of benzodiazepines in the treatment of alcoholism.

Benzodiazepines

Benzodiazepines

Benzodiazepines

Benzodiazepines

Benzodiazepines

From The Journal, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact the group, at (416) 595-6150.

17 . . . Going on Nowhere

Number: 522.
Subject Heading: Attitudes, communication.
Details: 30 min, 16 mm, color.
Synopsis: After a series of conflicts over curfews, looking after a younger brother, and a girlfriend, Pat's father forcibly takes Pat on a camping trip saying they will stay out until things are settled. After sharing his fears with his father, Pat seems to be better prepared to deal with his own life.
General Evaluation: Fair to good. (3.9) This contemporary, well-produced film has high emotional impact. General broadcast was recommended.
Recommended Use: It would be of particular benefit to parents.

Thanks for the One Time

Number: 523.
Subject heading: Alcohol and the family, alcohol, and alcoholism overview.
Details: 45 min, 16mm, color.
Synopsis: A medical doctor is confronted by a colleague about his alcohol consumption. The doctor has left his family and refuses treatment until a family meeting makes him face up to his problem.
General evaluation: Very poor to poor (1.8). The audiovisual assessment group felt the confrontation techniques illustrated were manipulative and followed poor ethical procedures.
Recommded use: none.

Suffer the Children

Number: 524.
Subject heading: Alcohol and the family
Details: 16 min, 16mm, color.
Synopsis: Children living in a family where a parent is an alcoholic tell of their experiences, their fears, and their feelings of guilt.
General evaluation: Very good to excellent (5.6). This well-produced film is a good teaching aid. Public broadcast was recommended.
Recommended use: Of benefit to all adult audiences.

Smoking: Nico-teen

Number: 525.
Subject heading: Smoking.
Details: 11 min, 16mm, color.
Synopsis: Why are young girls smoking more than young men? The girls interviewed tell why they smoke. The film also shows strategies that schools are adopting in teaching students to say no.
General evaluation: Good (4.4). This well-produced film is a good teaching aid. Public broadcast was recommended.
Recommended use: Of benefit to educators developing smoking education programs.

She Drinks a Little

Number: 526.
Details: 31 min, 16mm, color.
Synopsis: Cindy, a high school student, must deal with problems at home because of her mother's drinking. Cindy denies her mother's problem until Mitch, another student, befriends her and tells of his own family problems and how Alateen has helped.
General evaluation: Good to very good (4.9). This well-produced film has high emotional content. Public broadcast was recommended.
Recommended use: Parents and young people would especially benefit.

Epidemic: Kids, Drugs and Alcohol

Number: 527.
Subject heading: Drugs and youth, youth and alcohol.
Details: 27 min, 16mm, color.
Synopsis: Alarming statistics are given to demonstrate that youth are using all kinds of drugs in such a way as to constitute an epidemic. The film also tries to illustrate the reasons for drug use.
General evaluation: Poor to fair (2.8) The review group felt the film relied too much on sensationalism and some of the research cited was not definitive enough to draw the conclusions given.
Recommended use: Although probably intended for adult audiences, this film would not likely be of benefit.

Care: The Wonder Drug

Number: 528.
Subject heading: Drug use and seniors.
Details: 19 min, 16mm, color.
Synopsis: Jackie, a senior citizen, tells of her experience with multiple prescriptions and over-the-counter drugs. She gives good advice on how to handle these.
General evaluation: Good (4.4). This contemporary film made valuable points about wise use of drugs by seniors.
Recommended uses: Of special benefit to senior citizens.

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Surgery patients fare better after 12-hour smoking ban

By Jean McCann

LAS VEGAS — Quitting smoking 12 hours before surgery could mean the difference between life and death for chronic smokers, say researchers at Vanderbilt University.

Lily Chen and J.R. Kambam advise that while "fairly healthy" smokers may not be at risk, the chronic smoker who is anemic or has heart disease could be at risk of either dying or becoming severely ill from lack of oxygen.

Dr Chen and Dr Kambam, assistant professors of anesthesiology at Vanderbilt, spoke at the annual meeting here of the American Society of Anesthesiologists.

Dr Kambam said that in 10 chronic smokers studied, carboxyhemoglobin rose to 6.5% of the blood.

"Smoking significantly raises carboxyhemoglobin in the blood, which interferes with oxygen delivery to the tissue at various levels," he said. "However, after quitting smoking for 12 hours, our chronic smokers had a drop in such levels to less than 1%, which is more what you see in non-smokers."

Dr Kambam also told **The Journal** it is important that visitors and others in the room do not smoke during the 12-hour period prior to surgery, since the rise in carboxyhemoglobin levels could also result from sidestream smoke.

The researchers said it should not be difficult to persuade surgical patients who smoke to quit for that period of time.

"Twelve hours is really not long to quit smoking," Dr Chen said.

She also suggested it might be possible for smokers to get a beneficial effect from quitting for even shorter periods of time, but this was not determined in the study.

Pubs try harder as beer buying slumps in Britain

LONDON — With the number of pubs growing slightly and per capita consumption of beer dropping, publicans in Britain are beginning to fight back.

A report by the Brewers Society of Britain indicates more pubs serve food than ever before, and more have video games, billiard tables, and slot machines. Pubs are even trying to coax families to the premises by creating space for young children.

The brewers report that Britain barely made it into the top 10 beer-drinking countries on a per capita basis, coming ninth, 50 pints a year behind the West Germans. Canadians, by comparison, placed thirteenth on the scale, a full 100 pints a year behind West Germans whose yearly intake came to 256 pints per person.

Others in the top five, after West Germany, were Czechoslovakia, East Germany, Australia, and Belgium.

In Britain, the number of pubs has grown marginally, the Brewers Society reports, but consumption has slowed, a reflection of the sharp increase in the price of beer and the world-wide drift toward wine and white spirits.

A pint in London now costs about 70 pence, or $1.55. In the past two decades, the price of beer has risen 448%, wine and spirits by 236%, government figures show.

Pubs compete for customers.

NEWS AND DEPARTMENT

More women seeking rehab/treatment in NB

By John Carroll

FREDERICTON — The number of women alcohol and drug abusers in New Brunswick seeking treatment and rehabilitation has increased significantly, says a report from the province's Alcohol and Drug Dependency Commission (ADDC).

Of 3,101 admissions to treatment (detoxification) centres in fiscal year 1981-82, 353 (11%) were women, an increase of 73% over the previous year.

In the same period, the number of patient days increased by 91% to 2,507, and the average stay was 11% longer at 7.1 days compared to 6.4.

Although totals for men in treatment increased, percentages were below those relating to women. Male admissions were up 9% (to 2,748 from 2,529), and patient days increased to 16,915 from 15,306. Average length of stay increased only marginally.

The report, from the research and evaluation department of the commission, notes the ADDC has gradually been providing more facilities for women, including some exclusively for their use.

Female admissions to the ADDC rehabilitation programs also showed increases. In fiscal 1981-82 admissions totalled 59, up 34% from the 44 of the previous year, and patient days climbed 36% to 1,480. Average stay increased by only 1% to 23.7.

In comparison, male admission to rehabilitation increased 10% to 348 and patient days were up 6% to 7,325. Average stay was down 4% to 21 days.

More women than men were receiving their first assistance, says the report. Of women, 49% had not been in treatment (detox) before, and 89% had not been in a rehabilitation program. Only 32% of men reported no previous detox admissions.

The study found males were more likely than females to be single, and females more likely to be widows than males were to be widowers. Both males and females were just as likely to be married, divorced, living common-law, or separated.

The highest percentage of female admissions was in the 19-29 years age group, followed by 50-59 (25%), 30-39 (21%), 40-49 (19%), 60-65 (6%), and less than 18 or more than 65, each 2%.

The male profile was 24% of admissions for both the 40-49 and 50-59 years age groups, 30-39 (23%), 19-29 (12%), 60-65 (10%) more than 65 (7%) and under 18 years, 1%.

On the basis of training, 35% of females reported that of homemaker, while 48% of males reported laborer.

Where major financial support was concerned, 43% of the females and 33% of the males were receiving public assistance. Eighteen per cent of females were dependent upon a spouse, compared to 1% of males. Only 11% of females reported a job was their means of support, compared to 29% of males. Pension recipients accounted for 10% of females and 16% of males, while 4% of females and 12% of males relied upon unemployment insurance benefits.

Of particular interest to the researchers was the finding that while 50% of males reported income of $0-$400 per month, 70% of females were in this income bracket.

While females generally reported having their first drink at a later age than did males, females reported the "age at which drinking became a problem" at ages similar to, or a little younger than males.

The small number of women admitted to rehab programs makes comparison with males unreliable. In comparision to the females admitted to treatment, a greater percentage entering rehab required and received a medical examination. Of the females admitted,. 64% used Antabuse (disulfiram). Marital status was similar for rehab and treatment patients.

New Books

by RON HALL

Interfaces Between Alcoholism and Mental Health

. . . edited by Earl X. Freed

This volume deals with questions and problems and is not intended for the layman. The editor has tried to assemble significant contributions to thought about the interfaces between alcoholism and mental health, though the papers do not provide final answers to the questions discussed. The way the book is organized is intended to highlight some of the intertwining. The first part deals with overviews of some of the ways in which alcoholism and mental health interrelate, both historically and in contemporary thought. The remaining sections look at four of these major interfaces. The second part examines mental-health-related models and conceptions of alcoholism. The third part presents papers dealing with interfaces between alcoholism and psychopathology. They explore whether there are etiological relationships between alcoholism and other psychiatric conditions, whether one can be an alcoholic and mentally healthy, and to what degree alcoholism and other forms of psychopathology can coexist. The next section discusses some psychodynamic aspects of alcohol use and misuse, and the final section deals with some mental health approaches to alcoholism treatment.

(Rutgers Center of Alcohol Studies, New Brunswick, NJ, 1982. 390 p. ISBN 0-911290-50-8)

A Marihuana Dictionary:

Words, Terms, Events, and Persons Relating to Cannabis

. . . by Ernest L. Abel

This dictionary represents a lexicon of the language that has surrounded marijuana usage over the years. Most of the mainly English-language terms are slang, but the dictionary also includes terms used in reference to the pharmacology and botany of the marijuana plant, as well as classic literary descriptions of the drug experience. Foreign terms are included in a separate appendix. The dictionary is etymological, including illustrative excerpts from various popular media to demonstrate the evolution of the words. Also included are now obsolete terms referring to the marijuana plant as a source of hemp, and information about people who have contributed to the history of marijuana and events associated with the drug and its use.

(Greenwood Press, 88 Post Road West, PO Box 5007, Westport, CT 06881, 1982. 136 p. $25. ISBN 0-313-23252-0)

Other Books

Principles and Applications of Mediolegal Alcohol Determination — Widmark, E.M.P. Biomedical Publications, Davis, 1981. Translated from the 1932 German edition. Micro-method for determination of ethyl alcohol in the blood; blood samples for forensic alcohol determinations; diffusion of alcohol into the tissue and its movement into body fluids and exhaled air by diffusion; kinetics; alcohol determinations in forensic autopsies. Bibliography, index. 163p. $74.58.

Coping With Teenage Depression: A Parent's Guide — McCoy, Kathleen. New American Library, New York, 1982. Facts about teenage depression; identification; coping; problems at school; medical problems; substance abuse and other risk-taking behavior; suicide; help. Appendix. 331p. $21.93.

Usage of Khat in Yemen and Recommendations Thereon — Al-Jaaid, Mayoud. Criminology Department, Ottawa University, Ottawa, 1982. Present usage; medical, social, economic and legal considerations; evaluation of the problem, solutions. Appendices, references, bibliography, index. 92p.

Women In Crisis — Russianoff, Penelope (ed). Human Sciences Press, New York, 1981. The issue of women in crisis; intervention; making change; includes a chapter dealing with reaching the middle-class alcoholic; treatment of women and substance abuse; innovative alcoholism programs for women; motivation of the alcoholic woman; pregnancy and drinking. Appendix, index. 319p.

This publication is indexed in

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DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Medical Device Technology in the '80s — Dec 6-8, Toronto, Ontario. Information: Canadian Association of Manufacturers of Medical Devices (CAMMD), 480 Garyray Dr, Toronto, ON M9L 1P8.

Ontario Psychiatric Association Annual Meeting — Jan 27-29, 1983, Toronto, Ontario. Information: Donna Gray, Assistant to the Program Chairman, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Teaching with Video Tapes — Jan 28, 1983, Montreal, Quebec. Information: Dr Yvonne Steinert, Kellogg Centre, Livingstone Hall, Montreal General Hospital, Cedar Ave, Montreal, PQ.

Detox Training Programs (Non-Medical) — Feb 7-11, Apr 11-15, June 6-10, 1983, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

36th Annual Convention of the Ontario Psychological Association — Feb 17-19, 1983, Toronto, Ontario. Information: Dr Carl Rubino, Convenor, OPA '83, 1407 Yonge St, Suite 402, Toronto, ON M4T 1Y7.

The Management of Employee Assistance Programs — Feb 23-25, 1983, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Recent Developments in Psychopharmacological Management — Mar 2, 1983, Montreal, Quebec. Information: Centre for CME, McGill University, 1110 Pine Ave West, Montreal, PQ H3A 1A3.

Drug Therapy — Mar 25-26, 1983, Regina, Saskatchewan. Information: CME Centre, University of Saskatchewan, 408 Ellis Hall, Saskatoon, SK S7W 0W0.

25th Annual Scientific Assembly of the College of Family Physicians of Canada — Apr 24-27, 1983, Toronto, Ontario. Information: George Ackehurst, Director of Communications, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Clinical Criminology: Current Concepts Symposium — Apr 27-29, 1983, Toronto, Ontario. Information: Ms Evon Essue, Conference Secretary, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Drug Therapy — April 28-29, 1983, Montreal, Quebec. Information: CME, McGill University, 1110 Pine Avenue West, Montreal, PQ H3A 1A3.

Medic Canada '83 . . . Toward the Year 2000 — May 29-31, 1983, Edmonton, Alberta. Information: Toby Fay Sykes, Medic Canada '83, 480 Garyray Dr, Toronto, Ontario M9L 1P8.

Canadian Guidance and Counselling Association 9th Biennial Conference — May 31-June 3, 1983, Fredericton, New Brunswick. Information: Richard Harvey, Conference Chairman, CGCA '83, Fredericton, NB E3B 5G1

25th Annual Meeting of the American Association for the Study of Headache — June 25-26, 1983, Toronto, Ontario Information: Executive Director, Seymour Diamond, 5252 N Western Ave, Chicago, Illinois 60625.

Fifth World Conference on Smoking and Health — July 10-15, 1983, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, Ontario K1A 0C1.

2nd World Congress on Prison Health Care — Aug 28-31, 1983, Ottawa, Ontario. Information: Congress Secretariat, Medical Services Branch, The Correctional Service of Canada, Ottawa, ON K1A 0P9.

United States

9th Winter Midwest Institute of Alcohol Studies — Jan 9-14, 1983, Kalamazoo, Michigan. Information: Margaret M. Bernhard, Division of Continuing Education, Western Michigan University, Kalamazoo, MI 49008.

Diagnosis and Treatment of Headache — Jan 12-15, 1983, Scottsdale, Arizona. Information: Seymour Diamond, MD, American Association for the Study of Headache, 5252 N Western Ave, Chicago, Illinois 60625.

International Symposium on the Psychobiology of Alcoholism — Jan 16-18, 1983, Beverly Hills, California. Information: Health Sciences, UCLA Extension, PO Box 24901, Los Angeles, CA 90024.

Update and Training Workshop on Alcoholism Clinical and Treatment Planning Requirements of the Joint Commission on Accreditation of Hospitals — Jan 17-18, 1983, Los Angeles, California. Information: Kim Hilberg Farthing, Program Coordinator, National Association of Alcoholism Treatment Programs (NAATP), 1300 Bristol St N, Newport Beach, CA 92660.

8th Annual Alcholism Symposium: Intervention — The Key to Treatment and Recovery — Jan 19-21, 1983, Sacramento, California. Information: Gordon Stirling, Symposium Chairman, The Community Forum on Chemical Dependency, Inc, PO Box 13871, Sacramento, CA 95813.

Alcoholism — The Search for the Sources — Jan 19-21, 1983, Raleigh, North Carolina. Information: Sparky Carpenter, Information Specialist, PO Box 6507, Raleigh, NC 27628.

Fourth Training Institute on Addictions — Jan 27-Feb 1, 1983, Clearwater Beach, Florida. Information: Dan Barmettler, Director, The Institute for Integral Development, PO Box 2172, Colorado Springs, Colorado 80901.

1983-84 Chemical Dependency and Family Intimacy Training Project — Feb 1983-Feb 1984, Minneapolis, Minnesota. Information: CDFI Training Project, Program in Human Sexuality, University of Minnesota, 2630 University Ave SE, Minneapolis, MN 55414.

Family Dynamics of Alcohol/Drug Dependence — Feb 14-16, 1983, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N PArk Ave, Indianapolis, IN 46205.

Counselling Theories and Techniques — Mar 21-23, 1983, Indianapolis, Indiana Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

2nd Health and Addictions Seminar — Mar 27-Apr 1, 1983, Park City, Utah. Information: Dan Barmettler, Director, The Institute for Integral Development, PO Box 2172, Colorado Springs, Colorado 80901.

National Alcoholism Forum, "Marketing the Message" — Apr 14-17, 1983, Houston, Texas. Information: Louisa Macpherson, Forum Coordinator, National Council on Alcoholism, 733 Third Ave, Ste 1405, New York, New York 10017.

American Medical Society on Alcoholism — Apr 14-20, 1983, Houston, Texas. Information: J. Chen See, MD, AMSA, 733 3rd Ave, New York, New York 10017.

American Lung Association — May 8-11, 1983, Kansas City, Missouri. Information: Dir J. A. Swomley, 1740 Broadway, New York, New York 10019.

7th World Conference of Therapeutic Communities — May 8-13, 1983, Chicago, Illinois. Information: Donna Gleixner, Gateway Houses Foundation, Inc, 624 S Michigan Ave, Chicago, IL 60605.

Scholarly Communication Around The World — The 27th Annual Conference of the Council of Biology Editors, The 3rd International Conference of Scientific Editors and The 5th Annual Meeting of the Society for Scholarly Publishing — May 15-20, 1983, Philadelphia, Pennsylvania. Information: 1983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Service, 2100 Arch St, Philadelphia, PA 19103.

2nd Annual Conference on Alcoholism and the Family — May 25-29, 1983, Philadelphia, Pennsylvania. Information: Richard W. Esterly, Chairman, National Conference on Alcoholism and the Family, Box 277, Wernersville, PA 19565.

World Congress on Mental Health — July 22-28, 1983, Washington, DC. Information: World Federation for Mental Health, #107-2352 Health Sciences Mall, University of British Columbia, Vancouver, British Columbia V6T 1W5.

7th Annual Summer Institute of Drug Dependence — Aug 14-19, 1983, Colorado Springs, Colorado. Information: Dan Barmettler, Director, The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Abroad

International Conference on KHAT — The Health and Socio-Economic Aspects of KHAT Use — Jan 17-21, 1983, Antananarivo, Madagascar. Information: Archer Tongue, Director, International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

NSAD 10th Biennial Summer School on Alcohol, Drugs and Chemical Dependency — Jan 26-28, 1983, Wellington, New Zealand. Information: Bursar, Barbara Mills, NSAD, PO Box 1642, Wellington, New Zealand.

World Conference on Alcoholism — Feb 26-Mar 6, 1983, London, England. Information: Pat Fields, Charter Medical Corp, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, Georgia 30342.

World Symposium on Acupuncture — May 26-29, 1983, Bombay, India. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

9th International Conference of the International Association for Accident and Traffic Medicine — July 10-15, 1983, Mexico. Information: Dr R. Andreasson, IAATM, PO Box 10043, 5-100 55 Stockholm 10, Sweden.

7th World Congress of Psychiatry — July 11-16, 1983, Vienna, Austria. Information: Congress Team International, PO Box 9, A1095 Vienna, Austria.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, 1983, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

Middle Eastern Summer Institute on Drug Use (MESIDU): Techniques, Strategies, Concepts and Options — Sept, 1983, Jerusalem, Israel. Information: Stan Einstein, PhD, Director, MESIDU, 113/41 East Talpiot, Jerusalem, Israel.

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, 1983, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, 1983, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Services, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, 1983, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

The not-so-funny business of greeting card humor

By Betty Lou Lee

Ever since American comedian W. C. Fields made the red nose synonymous with over-imbibing, and the drunk whose only visible means of support was a lamp post staggered across the vaudeville stage, North Americans have been laughing at intoxication.

People solemnly view with alarm the learned studies about its social, human, and economic costs, but they still get a giggle out of *"Wasn't that a party!"*

The message that drunkenness is hilarious is sent to the drinker in the jocular way friends recount his escapades at last night's party. It's also sent in the mail.

Whatever the occasion, short of bereavement, there's a greeting card that says drinking is appropriate, fun, funny, or even essential.

They go around the calendar, from the Happy New Year card with its flowing champagne to a tipsy Santa enjoying a brandy rather than the traditional milk and cookies.

A United States study of studio cards (the tall, humorous variety) estimated that four million cards with a drinking theme are sold in the US every year.

Drinking ranked second, after sexual behavior, as the most popular subject.

Peter Finn, senior research analyst with Abt Associates Inc in Cambridge, Ma, surveyed studio cards by major manufacturers in 22 stores in six cities over a 12-month period.

He found 129 cards whose major theme was drinking and based his analysis on these. They were divided into five theme areas: getting drunk as part of celebrating; drunkenness as humorous, enjoyable, or harmless; problem drinking as humorous; drinking as medicinal; and drinking linked with sex. Many combined two or more of these themes.

In his analysis, the most popular message was that drunkenness is harmless: 95% fell into that category.

Thirty-two per cent depicted getting drunk as a concomitant of celebrations: 20% urged drunkenness and 11% assumed it.

One-quarter of the cards expressed the idea that drunkenness was enjoyable, and one-fifth that it was funny.

Twelve per cent ridiculed problem drinking, and 4% ridiculed loss of control.

Drinking and sex were linked in 6%, and 5% — mostly get-well cards — linked alcohol with the alleviation of emotional suffering or physical ills.

Writing in the *American Journal of Public Health*, Mr Finn said, "the possibility exists that repeated use of these cards may not merely reflect . . . tolerant attitudes toward alcohol abuse among the people who purchase and receive them, but may also legitimate or reinforce these attitudes and thereby contribute to their longevity, entrenchment, and pervasiveness.

"This is an important concern, because many of the attitudes expressed on these cards are felt by professionals in the fields of alcohol abuse prevention and treatment to contribute to the development of alcohol problems — or at least prevent or retard their recognition and solution."

A more recent, and more random, examination by **The Journal** of card displays in stores in two large Ontario cities yielded myriad examples for each of the Finn categories.

Even the Easter bunny gets into the act: "When they were handing out ears, I thought they said beers and I said, I'll have a couple of great big ones."

The drinking-sex theme can be mild: "Happy anniversary. This year why don't we do what we did on our honeymoon? — Drink champagne." Or it can be crass: "Dear wife. It's our anniversary and you know what that means — cold drinks and hot pants."

Thank-you cards can fall into the problem-drinking-as-humorous category: "Thank you for the great party — It was at your house wasn't it?"

On a medicinal theme, there are cards that say, "Stuck in the hospital? Here's how you can keep your chin up, keep a stiff upper lip and keep a smile on your face — Keep a bottle under your bed. Hope you feel better soon."

Or, "Sorry you're in the hospital. But cheer up — things could be worse. At least they keep your thermometer in alcohol." This card shows a woman patient gulping down the liquid while throwing the thermometer away.

Birthdays are probably the most common occasion for drinking-theme cards:

"Some advice for your birthday. Be very moderate in all that you do — after you reach 102. In the meantime, have fun." That one is illustrated by a laughing bear kicking up his heels and holding a glass of champagne.

"To celebrate your birthday, we could have a toga party . . . and get three sheets to the wind."

"It's your birthday, so ignore the ecologists . . . Get polluted."

"Try celebrating your birthday with some of my special hamburger helper . . . Actually, it's booze, but it helps everything."

Among birthday and graduation cards for the young adult set, a sub-theme of drinking as a rite of passage is not uncommon:

"Happy 21st birthday, and may your cup runneth over — Till you slippeth under the table. Cheers!"

"Be proud of your diploma, graduate! Think of what it stands for . . . 2,758 hours of studying! 137 books! 275 tests! . . . 1,987 beers. Congratulations!"

It's also easier to find drinking theme cards in outlets that serve campuses than in those that serve senior citizen apartment buildings.

One theme Mr Finn didn't delineate, but which becomes obvious, particularly in March, is the reinforcement of drinking stereotypes.

St Patrick's Day cards are awash with booze:

"St Patrick's Day riddle; If you had six bottles of Irish whiskey and I had six bottles of Irish whiskey, what would we have? Lunch."

"In honor of St Patrick's Day, let's drink to the 11 million Irish — One at a time."

"Know what crawls, wears green and goes about 1 mph? — An Irishman on his way home from a St Patrick's Day party."

In the world of greeting card humor, it's difficult to tell who is kidding whom.

THE BACK PAGE